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	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	4669 Falls Road Baltimore, MD 21209

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and interviews it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment for Residents. This finding was found to be evident during the tour of the facility for review of the physical environment.The findings include: On 4/14/26 at 8:19AM during an initial tour of the facility, the surveyor observed dark patches all over the bedroom floor. The vinyl chair cover was also torn in 3 different places, measuring about 1x6, 1x8 and 1x3 inches respectively. In room [ROOM NUMBER] bathroom, the floor vinyl behind the toilet, extending all the way to the bathroom sink and measuring about 3 x1.5 feet was raised and coming/peeling off. Behind the entrance door to room [ROOM NUMBER], the vinyl siding (Cove base) measuring about one foot long was observed hanging off the wall. In an interview with the maintenance director on 4/16/26 at 11:44 AM he was asked how things needing repair were brought to his attention and how he keeps the building maintained. He said he does a walk around on each wing and floor daily to see if staff or residents needed something fixed. They have a TELS system where maintenance /repair issues are logged in for him to see, residents can tell nurses or let him know directly. He was asked how soon he gets things fixed once he sees them in TELS and he said it depends on the urgency but relies mostly on staff to be his eyes and ears. The maintenance director #26 was made aware of the concerns, he said he will take care of them. During the initial tour of the Mount [NAME] Nursing Unit on 4/14/2026 at 8:00 AM the surveyor observed several areas in the Resident rooms not in good repair. room [ROOM NUMBER] – marred bathroom door; room [ROOM NUMBER] – marred bathroom door, marred wall behind head of Resident's bed; room [ROOM NUMBER] – bathroom door marred with chipped wood; room [ROOM NUMBER] – marred bathroom door, hole in wall in Resident's room; room [ROOM NUMBER] – marred bathroom door, black substance on the ceiling and the wall near the ceiling vent above the entrance door to the Resident's room; room [ROOM NUMBER] – bathroom door marred; and room [ROOM NUMBER] – bathroom door marred, toilet stopped up and will not flush. Additionally, there were missing wall tiles on the lower 1/3 of the wall in the nourishment room. At 12:30 PM on 4/17/2026 the surveyor toured Mount [NAME] Nursing Unit with the Maintenance Director and observed the hole in the wall in Resident room [ROOM NUMBER], the marred and chipped wood on Resident bathroom doors, and the missing wall tiles in the nourishment room. The Maintenance Director indicated that he does scheduled maintenance in the facility, and that he would (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get right on these areas that needed repair and order the necessary items to complete the repairs. No additional information was provided by the facility at the time of survey exit.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to ensure 1) written information was provided to a resident's representative regarding the facility's bed hold policy, and 2) written notice of the transfer was provided to a resident's representative upon transfer to the hospital and 3) failed to provide timely notification to the facility's Ombudsman when Residents transferred to the hospital. This was evident for 3 (Resident #3, #13, and #73) out of 6 residents reviewed for hospitalization and discharge process.The findings include:1) On 04/14/2026 at 9:12 AM, review of Resident #3's medical record revealed he/she was sent to the hospital on 2/11/2026. At the same time, further review of Resident #3's medical record revealed a document titled, Bed Hold Agreement, dated 2/11/26 which had hand written wording of, consent over the phone, and a signature below it on the bottom of the document. On 04/16/2026 at 11:29 AM, an interview with the Director of Nursing revealed that if a resident was able to acknowledge and sign the document they would provide the document to them, but otherwise staff would call the resident representative, note the communication on the document, and sign. The surveyor reviewed the concern. 2) On 04/14/2026 at 9:37 AM, review of Resident #3's medical record revealed a document titled, SNF/NF to Hospital Transfer Form, dated 2/11/2026 which indicated that the Resident's representative was notified of the transfer and aware of the clinical situation at the time of transfer, along with their telephone number. Further review of the document and medical record failed to reveal indication that there was a written form of notice provided to the Resident's representative upon transfer to the hospital. On 04/16/2026 at 11:29 AM, an interview with the Director of Nursing revealed that resident representatives were informed via telephone when a resident is transferred to the hospital. She confirmed the notice was not in written form. The surveyor reviewed the concern. 3) The surveyor reviewed Resident #13's medical record on 4/15/2026 at 9:30 AM. Record review revealed that Resident #13 transferred to the hospital on [DATE] for critical abnormal lab values. There was no indication in the medical record that the facility's Ombudsman was notified of the transfer to the hospital. On 4/15/2025 at 9:45 AM the surveyor conducted a record review of Resident #73's medical record. Review of the medical record revealed that Resident #73 transferred to the hospital on [DATE], 2/18/2026 and 3/8/2026. There was no indication in Resident #73's medical record that the facility's Ombudsman was notified of these transfers to the hospital. At 10:15 AM on 4/15/2026 the surveyor asked the Director of Nursing (DON) who was responsible for notification to the Ombudsman of hospital transfers. The DON acknowledged that Social Services Department was responsible for notification and requested documentation of these transfers to hospital for Resident #13 and #73. In an interview with the Social Services Director (SSD) at 11:17 AM on 4/15/2026 the surveyor asked what the process was for notification to the Ombudsman when Residents transferred to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSD indicated that he sends an email to the Ombudsman monthly with a list attached from the electronic medical record platform of Resident transfers and discharges from the previous month. The surveyor requested a copy of the email notifications to the Ombudsman for the months of October 2025, November 2025, February 2026 and March 2026. The surveyor reviewed on 4/15/2025 at 12:30 PM the emails and the electronic medical record list of discharges that were sent to the Ombudsman by the SSD. On 3/2/2026 at 1:58 PM the SSD emailed the 2025 discharge report to the Ombudsman, and on 3/2/2026 at 2:02 PM the SSD emailed the January 2026 discharge report to the Ombudsman, and on 4/15/2026 at 11:01 AM the SSD emailed February 2026 and March 2026 discharge report to the Ombudsman. In a follow up interview at 2:45 PM on 4/15/2026 with the SSD he stated that on 3/2/2026 he sent an email to the Ombudsman with all the Resident transfers and discharges for year 2025 as he was not notifying the Ombudsman of Resident transfers to the hospital until 3/2/2026 when he sent the email. Additionally, SSD stated that for January of 2026 he sent the email to the Ombudsman on 3/2/206 and for February and March 2026, he sent the email today (4/15/2026). At 3:35 PM on 4/15/2026 the Licensed Nursing Home Administrator (LNHA) was notified of the lack of Ombudsman notification of Resident transfers to the hospital. On 4/20/2026 at 1:30 PM the surveyor asked the Ombudsman if she was being notified of the hospital transfers, and she indicated that she had not been notified of Resident hospital discharges until recently.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record reviews it was determined that the facility failed to ensure that the Residents received the posted menu meal timely and the meal ticket matched the provided meal on Resident trays. This finding was found to be evident in 10 (Resident #80, #123, 6, 31, 60, 77, 91, 92, 100 and 111) out of 10 Residents reviewed for food and nutrition services.The findings include:In an interview with Resident #80 at 11:10 AM on 4/14/2026 the Resident stated that the food was awful, there were not enough portions, and the meal on the tray did not match the meal ticket. Resident further stated that he/she was supposed to get 2 juices and double portions of the meal, but he/she only received 1 juice and not enough portions of the meal. The surveyor reviewed Resident #80's meal ticket for breakfast on 4/14/2026 which the Resident had laying on the overbed table and the meal ticket indicated give 2 juices, entree x2 portions.In an interview with Resident #123 at 11:20 AM on 4/14/2026 the Resident stated that the food was not good and that there was not enough food provided. The Food Services Director at 11:30 AM on 4/14/2026 was notified of the concerns from Residents regarding the food not good, awful, and not enough portions of food.The surveyor conducted a record review of Resident #80's medical record on 4/17/2026 at 11:33 AM. Record review revealed that Resident #80 had a physician order for Heart Healthy, Controlled Carbohydrate, regular consistency diet. The surveyor conducted a record review of Resident #123's medical record on 4/17/2026 at 2:15 PM. Record review revealed that Resident #123 had a physician order for Regular diet, Regular texture, Regular (thin) liquid consistency.The surveyor observed the tray line for the lunch meal on 4/16/2026. The tray line began at 11:27 AM and completed at 1:15 PM. The menu posted for lunch consisted of Farmer's Meatloaf, mashed garlic potatoes, green peas, brown gravy and strawberry shortcake parfait. During the lunch tray line service on 4/16/2026 the dietary department ran out of 2 food items (meatloaf and peas) and did not have enough food to prepare the posted menu meal for 8 Residents (# 6, #31, #60, #77, # 91, #92, #100 and #111) on the Cross Keys Nursing Unit. These 8 Residents received a substitute lunch meal which consisted of beef slices, corn, mashed garlic potatoes, brown gravy and strawberry shortcake parfait.The facility's Food Service Director (FSD) and the District Food Services Director were present in the kitchen when the dietary staff ran out of the 2 food items (meatloaf and green peas) that were on the posted menu for the lunch meal on 4/16/2026. The FSD at 1:00 PM prepared the substitute beef slices for the 8 Residents, and the District Director went to another facility to obtain the meatloaf.At 1:50 PM on 4/16/2026 the Licensed Nursing Home Administrator (LNHA) was notified that the kitchen ran out of the posted menu meal for lunch (meatloaf and green peas). The LNHA acknowledged the surveyor and indicated that he had been notified by the FSD.No additional information was provided by the facility at the time of survey exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record reviews, it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards for sanitation and food service safety. This finding was found to be evident in the kitchen and on the Mount [NAME] Nursing Unit during the annual recertification survey.The findings include:On tour of the facility's kitchen on 4/14/2026 at 7:10 AM with 3 dietary employees (#7, #8 and #11) in attendance the surveyor observed sanitation concerns: 1) employee's personal items - pink mug, foil wrapped food, and bottle of water on the small utility cart, 2) no running water in one of the hand sinks and standing water not draining in the other hand sink, 3) hole in the wall by the kitchen window where the telephone had fallen off the wall, 4) reach-in refrigerator missing documentation of temperature readings for 4/12 and 4/13, 5) food items not dated in the walk-in freezer - cardboard box of sandwich slices and waffles opened not dated, vegetables opened not dated, 6) build-up of ice on the freezer ceiling and the freezer door, 7) food items not dated in the walk-in freezer - cardboard box of bacon strips opened 2/3 full not dated, jar of grape jelly opened not dated, and 8) dry storage room with a black substance near the baseboard behind the center metal shelf.At 7:45 AM on 4/14/2026 the Licensed Nursing Home Administrator (LNHA) was notified of these concerns with the sanitation in the kitchen.On 4/14/2026 at 9:15 AM the Food Services Director was notified of these concerns with the sanitation in the kitchen. At 1:30 PM on 4/16/2026 the surveyor observed the food delivery cart sitting at the elevator on the Mount [NAME] Unit. There were 2 meal trays sitting on top of food delivery cart and the meal trays inside the food delivery cart had not been delivered to the Residents. At 1:37 PM the surveyor notified the Unit Manager who observed the food delivery cart sitting at the elevator with meal trays inside the cart. The Unit Manager indicated that she thought that meal trays on the food delivery cart had already been delivered to the Residents.The Director of Nursing (DON) was notified at 1:45 PM on 4/16/2026 of the concern with the delivery of the meal trays on the Mount [NAME] Unit.The surveyor observed the nourishment refrigerator on the Mount [NAME] Nursing Unit at 2:10 PM on 4/16/2026. Observation revealed that food items were not labeled with the Resident's name and dated: 1) Pepsi bottle, 2) cranberry juice bottle, 3) plastic bag of grapes, and 4) gray lunch bag with orange trim.In an interview with the Nurse Unit Manager at 2:15 PM on 4/16/2026 the surveyor asked what the expectation was for labeling and dating food items in the nourishment refrigerator. The Unit Manager indicated that the food items were to be labeled with the Resident's name and date. Additionally, the surveyor confirmed with the Unit Manager that the nourishment refrigerator was for storage of Resident's food.The surveyor on 4/16/2026 at 3:10 PM conducted a record review of the facility's policy for Foods Brought by Family and Visitors dated 11/25. The policy indicated that foods stored in the refrigerator are labeled with Resident's name and dated.No additional information was provided by the facility at the time of survey exit.

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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 interviews and surveyor record reviews it was determined that the facility failed to develop and implement a comprehensive care plan for a Resident. This finding was found to be evident in 1 (Resident #119) out of 1 Resident reviewed for anticoagulant medication usage. The findings include:Anticoagulants or blood thinners are medications that prevent blood clots from forming or growing by inhibiting clotting factors. The primary side effect of anticoagulants is increased bleeding, requiring careful monitoring. Minimum Data Set (MDS) Assessment is a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid- certified nursing homes to evaluate Resident functional capabilities, health needs, and preferences. The MDS assessment drives care planning, quality monitoring, and reimbursement, with assessments conducted upon admission, quarterly, annually, and upon significant status changes. The MDS assessment is completed by licensed health care professionals in nursing homes. Data is submitted electronically to state databases.Care Plan is a written document that outlines a person's care needs and how they will be met. The care plan includes health information related to medical history, current treatments, medications, and health care providers. Care plans should be regularly reviewed to monitor their effectiveness. The care plan guides the health care professionals in delivering care to Residents.At 10:24 AM on 4/14/2026 in an interview with Resident #119 the Resident stated that he/she takes a blood thinner.The surveyor conducted a record review of Resident #119's medical record on 4/16/2026 at 2:15 PM. Record review revealed that Resident #119 had an active physician order for Rivaroxaban (Xarelto)10 mg by mouth at bedtime for DVT (deep vein thrombosis) with an order date of 2/12/2026. Rivaroxaban (Xarelto) is an anticoagulant medication. Additionally, there was an active physician order for Anticoagulant Side Effect Monitoring every shift for Anticoagulant use. Further review of the medical record revealed that the MDS assessment Medicare 5 Day dated 2/19/2026 was coded that Resident was taking an anticoagulant medication. Upon review of Resident #119's comprehensive care plan there was not a plan of care for anticoagulant medication usage. In an interview with the Director of Nursing (DON) at 3:10 PM on 4/16/2026 the surveyor asked what the expectation for care planning was for Resident usage of anticoagulant medication. The DON stated that the expectation was that the anticoagulant medication should be addressed on the Resident's care plan. The surveyor conveyed that Resident #119 had an active physician order for Rivaroxaban (Xarelto), but there was no comprehensive care plan for anticoagulant medication usage and that the MDS assessment was coded that Resident was taking an anticoagulant medication. The surveyor reviewed with the DON Resident #119's physician orders, MDS assessment and comprehensive care plan and the DON acknowledged that Resident did not have a comprehensive care plan for anticoagulant medication usage.No additional information was provided by the facility at the time of survey exit.

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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 interview and record review, it was determined that the facility failed to ensure that a resident received quarterly care plan meetings. This was evident for 1 (Resident #6) of 4 residents reviewed for care planning.The findings include:On 04/14/2026 at 8:01 AM, an interview with Resident #6 revealed that they were unaware of the last care plan meeting they had, but that it had been a while. On 04/14/2026 at 12:36 PM, review of Resident #6's medical record revealed the last documented care plan meeting was 7/30/2025.On 04/16/2026 at 9:08 AM, an interview with the Social Services Director (Staff #9) revealed that care plan meetings were done quarterly after each quarterly comprehensive assessment. The surveyor requested documentation of the last care plan meeting for Resident #6.On 04/16/2026 at 12:57 PM, review of the last care plan meeting note provided by the facility was dated 7/30/2025. Staff #9 had no further documentation that would indicate a care plan meeting was held since 7/30/2025.On 04/16/2026 at 1:34 PM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interviews and record reviews, it was determined that the facility failed to provide communication tools for a resident who is unable to communicate appropriately. This was evident for 1 (Resident #12) of 1 resident reviewed for language and communication during the annual survey.The findings includeOn 4/14/2026 at 11:07 AM Resident #12 was observed on a wheelchair to the right side of the bed in their room. The bed was between the wheelchair where the resident was sitting and the nightstand. The resident is alert and oriented. In his neck is a trach stoma, a surgical opening in the neck to facilitate breathing. An oxygen (o2) humidifier was attached to the trach site. The resident can only mouth words, so it was difficult to understand all they were trying to say. There is no communication board in sight or at the bedside. The surveyor was trying to communicate with the resident but was unable to read lips or understand everything the resident was trying to say. The surveyor requested to speak with the resident's nurse.On 4/14/2026 at 11:22 AM In an Interview with the residents nurse a License Practical Nurse (LPN) 25, she was asked how she communicates with Resident #12 and she said that she read lips, that resident takes time to communicate. She was asked if the resident has an alternate means to communicate like a communication board. LPN #12 said that the resident use to have one at the bedside but there is none currently. The surveyor asked about people who couldn't read lips or understand what the resident was trying to say and asked how they communicate with the resident and if there was another form of communication for the resident and she said there was none. Review of Resident #12's care plan on 4/14/2026 at 11:37 AM documented that resident has a trach and to provide means of communication, there was none at the bedsideIn an Interview with the Director of Nursing (DON) #3 on 4/16/2026 at 11:27 AM, she was asked about the expectations for residents who have trouble communicating to help the staff communicate with them. She stated that staff are expected to do frequent rounding and make sure things are within reach. She was asked if there should be an alternate form of communication and she said those residents should have a communication board at the bedside. The DON #3 was made aware of the concern that Resident #12 did not have one and she acknowledged it.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interviews, facility staff failed to provide adequate supervision to prevent Resident #1, a vulnerable, cognitively impaired resident with a history of falls, from experiencing a fall that resulted in a major injury. This was evident for 1(Resident #1) of 64 residents reviewed during the annual survey.The findings included:On 04/14/2026 at 8:57 AM: During the initial observation, a blue fall mat was observed on the floor, located just behind the curtain upon entering Resident #1's room.On 04/16/2026 at 8:46 AM: A record review of Resident #1's progress notes from 6/24/2025 at 8:11 AM revealed a fall had occurred. The documentation stated that a nurses' aide on the 11-7 shift informed the nurse that, while providing morning care and turning the resident on their side for cleanup, the aide could not control the resident and lowered them to the floor. The resident was helped back to bed, assessed, and no injuries were noted at that time; the physician was notified. 6/24/2025 at 3:26 PM: Further record review of the progress notes revealed that Resident #1 complained of pain in their left hip. Pain medicine was given and an X-ray was ordered. 6/24/2025 at 11:23 PM: The physician was made aware of the X-ray results and gave an order to send the resident to the hospital. A review of the discharge summary from the hospital revealed Resident #1 was admitted to the hospital on [DATE], at 3:42 AM with diagnoses including Left Femur Subacute Fracture, COPD, Pneumonia, Hypoxia, and Dementia. On 04/16/2026 at 12:15 PM: A review of the Minimum Data Set (MDS) assessments dated 11/10/24, 2/10/25, and 5/13/25, section GG (Functional Abilities), showed Resident #1 was consistently documented as dependent (01) for roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. The MDS coding guide specified scoring assistance based on the amount of help required for safety and quality of performance. Documentation showed the resident was dependent for repositioning for over a year. On 04/16/2026 at 1:45 PM: The Director of Nursing (DON), Staff #3, was asked to provide documentation regarding the required staffing assistance for Resident #1. The DON provided documentation dated 7/2/2025, which showed Resident #1 was designated as a two-person assist starting on 7/2/2025, the day the resident returned from the hospital. Further record review revealed Resident #1 was placed in Hospice care on 7/3/2025, the day after returning from the hospital. On 04/17/2026 at 6:53 AM: Staff #17, Geriatric Nursing Assistant (GNA), was interviewed. Staff #17, GNA confirmed their witness statement from the incident on 6/24/25, stating they were doing morning care alone and, while attempting to turn the resident, could not control them, leading the aide to guide the resident to the floor between the bed and the cabinet. Another GNA then assisted using a Hoyer lift to return the resident to bed. On 04/17/2026 at 7:49 AM: The DON was shown the MDS assessments (11/10/24, 2/10/25, and 5/13/25, section GG) which documented that Resident #1 had been dependent on turning from side-to-side safely since at least 2024. Resident #1 was not designated as a two-person assist until 7/2/2025, after the resident fell, sustained a fracture, and returned from the hospital. The DON verbalized understanding that Resident #1 not being a two-person assist prior to the fall was an issue and provided documentation that an audit for residents requiring assistance with bed mobility was completed on 6/30/25.

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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 observations, interviews and surveyor record reviews it was determined that the facility failed to maintain appropriate respiratory care and services. This finding was found to be evident in 2 (Resident #27 and #66) out of 2 Residents reviewed for oxygen usage.The findings include:Oxygen concentrators are FDA-regulated medical devices that filter nitrogen from ambient air to deliver concentrated, high purity oxygen to Residents with chronic lung conditions. They offer a continuous, non-refillable supply of oxygen for home or portable use. Oxygen concentrators pull in surrounding air, compress it, remove nitrogen, and deliver purified oxygen through a nasal cannula or mask. A prescription is required.At 11:42 AM on 4/14/2026 the surveyor observed Resident #27 in bed in no distress with an oxygen concentrator at the bedside with oxygen in use. There was no no smoking/oxygen in use signage on the Resident door or the door frame that indicated oxygen was in use.At 12:05 PM on 4/14/2026 the surveyor observed Resident #66 in bed in no distress with an oxygen concentrator at the bedside with oxygen in use. There was no no smoking/oxygen in use signage on the Resident door or the door frame that indicated oxygen was in use.The surveyor conducted a record review on 4/15/2026 at 10:00 AM of Resident #27's and #66's medical record. The review revealed that both Residents had physician orders for oxygen 2 Liters via nasal cannula.In an interview with the Director of Nursing (DON) at 10:23 AM on 4/15/2026 the surveyor conveyed that Resident #27 and Resident #66 both had oxygen concentrators in their rooms with oxygen in use, but there was no oxygen signage on their room doors or door frames which indicated that oxygen was in use. The DON stated that she was surprised as the facility used a lot of oxygen. The surveyor with the DON in attendance observed both Resident #27 and #66 in bed with oxygen in use with an oxygen concentrator and did not have oxygen signage on the room doors or door frames. On 4/15/2026 at 12:30 PM the surveyor reviewed the facility's Oxygen Therapy Policy dated 12/25. The policy indicated that The purpose of this procedure is to provide guidelines for safe oxygen therapy and Steps in the procedure indicated 2. Place an Oxygen in Use sign on the outside of the room entrance door.No additional information was provided by the facility at the time of survey exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure a resident received pharmaceutical services to meet their needs regarding timely medication administration. This was evident for 1 (Complaint #2968846) of 5 complaints reviewed during the annual survey.The findings include:Medications are ordered by the physician to meet a resident's needs. They are ordered for specific times for a reason to reflect the resident's plan of care and needs.Medications should be administered an hour prior or after the ordered/scheduled time.On 04/14/2026 at 1:02 PM, review of Complaint #2968846 revealed a concern that medications were not administered to Resident #136 timely based on the order.On 04/14/2026 at 1:14 PM, review of Resident #136's medical record revealed he/she was admitted to the facility on [DATE] and was discharged on 2/14/2026.On 04/16/2026 at 11:24 AM, review of Medication Administration Record (MAR) Audit for January 2026-February 2026 requested by the surveyor revealed the following dates and medications which the Resident received late:1/21/2026 Atovaquone (prevents lung infection) oral suspension 750MG/ML ordered for 6:00 PM was administered at 8:41 PM.1/23/2026 Atovaquone oral suspension 750MG/ML ordered for 6:00 PM was administered at 7:54 PM.1/23/2026 Tramadol (strong pain medication) HCl oral tablet 50 MG ordered for 6:00 PM was administered at 7:53 PM.1/24/2026 Vitamin D-3 (vitamin supplement) oral tablet 125 MCG ordered for 8:00 AM was administered at 11:43 AM.1/24/2026 Dexamethasone (reduce inflammation/weaken immune system) oral tablet 2 MG ordered for 9:00 PM was administered on 1/25/2026 at 7:18 AM.1/24/2026 Flomax (helps men urinate) oral capsule 0.4 MG ordered for 9:00 PM was administered on 1/25/2026 at 7:19 AM.1/24/2026 Levetiracetam (prevents seizures) oral tablet 750 MG ordered for 9:00 PM was administered on 1/25/2026 at 7:19 AM. 1/24/2026 Apixaban (blood thinner) oral tablet 5 MG ordered for 9:00 PM was administered on 1/25/2026 at 7:19 AM.1/24/2026 Temozolomide (chemotherapy) oral capsule 140 MG ordered for 9:00 PM was administered on 1/25/2026 at 7:19 AM.1/25/2026 Vitamin D-3 oral tablet 125 MCG ordered for 8:00 AM was administered at 10:18 AM.1/26/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was administered at 1:42 PM.1/28/2026 Vitamin D-3 oral tablet 125 MCG ordered for 8:00 AM was administered at 10:11 AM.1/29/2026 Amlodipine Besylate (reduces high blood pressure) oral tablet 2.5 MG ordered for 9:00 AM was administered at 2:34 PM.1/29/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was administered at 2:36 PM.1/30/2026 Amlodipine Besylate oral tablet 2.5 MG ordered for 9:00 AM was administered at 11:54 AM.1/31/2026 Vitamin D-3 oral tablet 125 MCG ordered for 8:00 AM was administered at 9:51 AM.1/31/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was administered at 2:01 PM.1/31/2026 Amlodipine Besylate oral tablet 2.5 MG ordered for 9:00 AM was administered at 3:46 PM.2/03/2026 Oxycontin (strong pain medication) oral tablet 10 MG ordered for 9:00 PM was administered at 10:34 PM.2/03/2026 Dexamethasone oral tablet 2 MG ordered for 9:00 PM was administered at 10:34 PM.2/03/2026 Apixaban oral tablet 5 MG ordered for 9:00 PM was administered at 10:34 AM.2/03/2026 Flomax oral capsule 0.4 MG ordered for 9:00 PM was administered at 10:34 PM.2/03/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 PM was administered at 10:34 PM.2/04/2026 Tramadol HCl oral tablet 50 MG ordered for 6:00 PM was administered at 8:18 PM.2/04/2026 Atovaquone oral suspension 750MG/ML ordered for 6:00 PM was administered at 8:18 PM.2/05/2026 Gabapentin (muscle relaxer) oral tablet 100 MG ordered for 9:00 PM was administered at 10:35 PM.2/05/2026 Dexamethasone oral tablet 2 MG ordered for 9:00 PM was administered at 10:35 PM.2/05/2026 Apixaban oral tablet 5 MG ordered for 9:00 PM was administered at 10:35 PM.2/05/2026 Flomax oral capsule 0.4 MG ordered for 9:00 PM was administered at 10:35 PM.2/05/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 PM was administered at 10:36 PM.2/05/2026 Oxycontin oral tablet 10 MG ordered for 9:00 PM was administered at 10:36 PM.2/07/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered at 2:28 PM.2/07/2026 Tramadol HCl oral tablet 50 MG ordered for 6:00 PM was administered at 8:26 PM.2/07/2026 Atovaquone oral suspension 750MG/ML ordered for 6:00 PM was administered at 8:26 PM.2/08/2026 Vitamin D-3 oral tablet 125 MCG ordered for 8:00 AM was administered at 10:00 AM. 2/08/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was administered at 2:10 PM. 2/10/2026 Tramadol HCl oral tablet 50 MG ordered for 12:00 PM was administered at 1:47 PM.2/10/2026 Gabapentin oral tablet 100 MG ordered for 9:00 PM was administered at 10:41 PM2/10/2026 Dexamethasone oral tablet 2MG ordered for 9:00 PM was administered at 10:41 PM.2/10/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 PM was administered at 10:41 PM.2/10/2026 Apixaban oral tablet 5 MG ordered for 9:00 PM was administered at 10:41 PM.2/10/2026 Flomax oral capsule 0.4 MG ordered for 9:00 PM was administered at 10:41 PM.2/11/2026 Gabapentin oral tablet 100 MG ordered for 9:00 PM was administered at 10:58 PM.2/11/2026 Dexamethasone oral tablet 2MG ordered for 9:00 PM was administered at 10:58 PM.2/11/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 PM was administered at 10:58 PM.2/11/2026 Flomax oral capsule 0.4 MG ordered for 9:00 PM was administered at 10:58 PM.2/11/2026 Apixaban oral tablet 5 MG ordered for 9:00 PM was administered at 10:58 PM.2/12/2026 Apixaban oral tablet 5 MG ordered for 9:00 AM was administered at 12:00 PM.2/12/2026 Pantoprazole (acid reflux reducer) oral tablet 40 MG ordered for 9:00 AM was administered at 12:01 PM.2/12/2026 Dexamethasone oral tablet 2MG ordered for 9:00 AM was administered at 11:59 PM.2/12/2026 Ondansetron (helps reduce nausea) oral tablet 8 MG ordered for 9:00 AM was administered at 12:00 PM.2/12/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 AM was administered at 12:00 PM.2/12/2026 Oxycontin oral tablet 10 MG ordered for 9:00 AM was administered at 12:00 PM.2/13/2026 Oxycontin oral tablet 10 MG ordered for 9:00 PM was administered at 01:32 AM.2/13/2026 Levetiracetam oral tablet 750 MG ordered for 9:00 PM was administered at 01:32 AM.2/13/2026 Dexamethasone oral tablet 2MG ordered for 9:00 PM was administered at 01:32 AM.2/13/2026 Flomax oral capsule 0.4 MG ordered for 9:00 PM was administered at 01:32 AM.2/13/2026 Apixaban oral tablet 5 MG ordered for 9:00 PM was administered at 01:32 AM.2/13/2026 Gabapentin oral tablet 100 MG ordered for 10:00 PM was administered at 01:32 AM.On 4/17/26 at 7:44 AM, an interview with the Director of Nursing revealed the expectations of staff was to administer medications between an hour before to an hour after the ordered/ scheduled time. She further indicated the time noted to be administered on the MAR audit was the time that the nurse would have administered the medications.At the same time, the surveyor revealed the list of dates and medications that were found to be administered late. The surveyor reviewed the concern and she indicated that she understood.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews it was determined that the facility failed to dispose of garbage and refuse properly. This finding was found to be evident in review of the outside dumpster area during the annual recertification survey. The findings include: The surveyor toured the outside dumpster area at 1:17 PM on 4/16/2026 with the Floor Technician in attendance. There were 2 dumpsters for trash and garbage and 1 dumpster for recyclables. Outside of the trash dumpster was multiple pieces of trash lying on the ground, a bag of trash behind the dumpster and the trash dumpster was not closed with the attached lid on top of the dumpster. The Licensed Nursing Home Administrator (LNHA) was notified of the concern with the outside dumpster area at 1:50 PM on 4/16/2026. At 6:45 AM on 4/17/2026 the surveyor followed up on the outside dumpster area with the Housekeeping Manager in attendance. Observed on the ground outside the dumpster was multiple pieces of trash, an empty large can of beans, empty juice cups, plastic gloves, and paper towels. At 8:45 AM on 4/17/2026 the Licensed Nursing Home Administrator (LNHA) was notified and stated that he had staff clean up the trash around the dumpster area that was observed the previous day.No additional information was provided by the facility at the time of survey exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and surveyor record review it was determined that the facility failed to maintain an accurate medical record for a Resident. This finding was found to be evident in 1 (Resident #27) out of 1 Resident reviewed for Resident records.The findings include:Anticoagulants or blood thinners are medications that prevent blood clots from forming or growing by inhibiting clotting factors. The primary side effect of anticoagulants is increased bleeding, requiring careful monitoring. Minimum Data Set (MDS) Assessment is a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid- certified nursing homes to evaluate Resident functional capabilities, health needs, and preferences. The MDS assessment drives care planning, quality monitoring, and reimbursement, with assessments conducted upon admission, quarterly, annually, and upon significant status changes. The MDS assessment is completed by licensed health care professionals in nursing homes. Data is submitted electronically to state databases.Care Plan is a written document that outlines a person's care needs and how they will be met. The care plan includes health information related to medical history, current treatments, medications, and health care providers. Care plans should be regularly reviewed to monitor their effectiveness. The care plan guides the health care professionals in delivering care to Residents.The surveyor conducted a record review of Resident #27's medical record on 4/15/2026 at 10:00 AM. The review of the medical record revealed that Resident #27 had an active physician order for Anticoagulant Side Effect Monitoring: Observe for Signs and Symptoms of Bleeding/Bruising every shift, document unusual findings in progress note and notify provider, every shift for Anticoagulant use. Further review of the medical record revealed that Resident #27 did not have an active physician order for an anticoagulant medication. Additionally, the MDS assessments dated 1/30/2026 Quarterly and 8/8/2025 Medicare 5 Day were not coded that Resident was taking an anticoagulant medication. Review of the current care plan for Resident #27 revealed that there was no care plan for usage of an anticoagulant medication.In an interview at 12:50 PM on 4/15/2026 with the Director of Nursing (DON) the surveyor conveyed that Resident #27 had a physician order for Anticoagulant Side Effect Monitoring every shift for Anticoagulant use; however Resident #27 did not have a physician order for an anticoagulant medication. Additionally, the surveyor conveyed that the MDS assessments dated 1/30/2026 Quarterly and 8/8/2025 Medicare 5 Day were not coded that Resident was taking an anticoagulant medication, and that there was no care plan for anticoagulant medication usage. The DON confirmed that Resident #27 did not have a physician order for an anticoagulant medication.No additional information was provided by the facility at the time of survey exit.

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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 interviews and surveyor record reviews it was determined that the facility failed to have a physician order for a Resident to receive Hospice care. This finding was found to be evident in 1 (Resident #73) out of 2 Residents reviewed for Hospice Services.The findings include:Minimum Data Set (MDS) Assessment is a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid- certified nursing homes to evaluate Resident functional capabilities, health needs, and preferences. The MDS assessment drives care planning, quality monitoring, and reimbursement, with assessments conducted upon admission, quarterly, annually, and upon significant status changes. The MDS assessment is completed by licensed health care professionals in nursing homes. Data is submitted electronically to state databases.Care Plan is a written document that outlines a person's care needs and how they will be met. The care plan includes health information related to medical history, current treatments, medications, and health care providers. Care plans should be regularly reviewed to monitor their effectiveness. The care plan guides the health care professionals in delivering care to Residents.The surveyor conducted a record review of Resident #73's medical record on 4/15/2026 at 10:45 AM. Record review revealed that the Census tab of Resident #73's electronic medical record indicated that the primary payer was Hospice Medicaid MD. As of 3/12/2026. Further review revealed that there was a significant change MDS assessment dated [DATE] which was coded for Hospice and a comprehensive care plan initiated 3/13/2026 for Resident #73 receiving Hospice services with [NAME] Hospice Care, INC. Continued review of the medical record revealed that there was no physician order for Hospice care and services by Resident #73's attending physician at the nursing home.Additionally, the surveyor reviewed [NAME] Hospice progress notes, evaluations and plan of care found in Resident #73's electronic medical record on 4/15/2026.At 1:30 PM on 4/15/2026 in an interview with the Director of Nursing (DON) the surveyor conveyed that Resident #73 was under Hospice Services with [NAME] Hospice Care, INC and there was a significant change MDS assessment coded for Hospice care and a care plan for Hospice Services from [NAME], but there was no physician order for Hospice care and services from the attending physician at the nursing home. DON acknowledged the surveyor and indicated that Resident #73 should have a physician order for Hospice care.In a follow-up review of Resident #73 medical record on 4/16/2026 at 9:30 AM the review revealed that there was now a physician order from the Resident's attending physician at the nursing home for Admit to Hospice. The order date and time stamp was by phone on 4/15/2026 at 23:18 (11:18 PM) with the current primary physician. At 9:55 AM on 4/16/2026 the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a copy of this Hospice order and the payer report for Resident #73 which indicated Hospice Medicaid MD as the payer as of 3/12/2026.No additional information was provided by the facility at the time of survey exit.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on staff interviews, review of pertinent documentation including the facilities Quality Assurance and Performance Improvement (QAPI) policy, and survey findings, it was determined the facility staff failed to 1.) track performance to ensure improvements are realized and sustained and 2.) failed to conduct at least one Performance Improvement Plan/Project (PIP) annually that focuses on problem prone areas identified by the facility through data collection and analysis. This was evident during review of the facilities Quality Assurance program.Findings include:1.) On 04/20/2026 at 11:11 AM, the Director of Nursing (DON), Staff #3, and the Assistant Director of Nursing (ADON), Staff #4, were interviewed regarding responsibility for the QAPI meeting and its operational process. Both stated that they are jointly in charge of QAPI. Staff #4 (ADON) further specified that all departments meet monthly and submit data for the QAPI meeting.When Staff #4 ADON was asked how data collected from QAPI meetings are regularly reviewed, analyzed, and acted upon, they responded by citing examples such as staff in-services or meeting weekly with the facility's wound team.Staff #3 DON and Staff #4 ADON were then shown documentation from their QAPI meeting minutes:10/22/25 QAPI Minutes:Antipsychotic benchmark: The total number of residents receiving Antipsychotics was 23, with 19 having a qualifying diagnosis. The goal met column was marked no, but the columns for action and PIP were blank.Other Areas (Call light response time, MOLST, UTI, wounds, and residents with significant weight loss greater than 5% in 30 days): For these items, the number of residents with significant weight loss was 8. Nothing was documented for goal met or not met, action plan, or PIP for the other areas listed above.11/26/25 QAPI Minutes: Documented a total of 5 resident falls. The listed actions included PT/OT, fall mats, toileting schedule, and purposeful rounding.12/11/25 QAPI Minutes: Documented a total of 24 falls, 3 residents with multiple falls, and 2 residents with injuries related to the fall. No action plan or PIP was documented. When asked to explain the increase in falls from November to December, no reply was given.1/29/26 QAPI Minutes: The documentation provided did not address falls, wounds, weights, or infections, and no actions or goals were documented.Staff #3 DON and Staff #4 ADON were again asked how they regularly review, analyze, and act on QAPI data and if they could provide documentation. Staff #4 ADON replied that they were lacking documentation, and no other information was provided.2.) On 04/20/2026 at 12:30 PM, the DON, Staff #3 was asked to provide a Performance Improvement Plan (PIP) addressing a high-risk issue or problem identified during QAPI meetings.On 4/20/2026 at 12:42 PM, the Staff #3, DON provided an audit for residents requiring assistance with bed mobility. When documentation for a PIP was specifically requested, the surveyor instead was shown an in-service related to medication administration. No other documentation was provided.

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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. Based on observation and interview with facility staff, it was determined that the facility failed to ensure that the environment of resident care was maintained in a manner that minimized the potential spread of infection as evidenced by an unwrapped toilet tissue roll placed on top of the red sharps bio-hazard container. This was evident for 1 (Resident #8) of 64 residents investigated during the annual survey.The findings include:On 04/14/2026 at 8:33 AM during the initial observation, an unwrapped roll of white toilet tissue was observed in Resident #8's bathroom sitting on top of the red sharps container. On 04/14/2026 at 8:46 AM the unwrapped toilet tissue in Resident #8's bathroom was shown to Staff #36, Licensed Practical Nurse, LPN. Staff #36, LPN stated they would call housekeeping to dispose of the tissue on top of the sharps container.On 04/14/2026 at 9:04 AM the Director of Nursing, (DON) was made aware of the issue and verbalized understanding that unwrapped tissues on the sharps container was an infection control issue. Housekeeping later removed the tissue.

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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 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 staff interviews, it was determined that the facility failed to have call bells within reach of a dependent resident. This was evident for 1 (Resident #12) of 1 resident reviewed for language and communication during the annual survey.The findings includeOn 4/14/2026 at 11:07 AM Resident #12 was observed in a wheelchair sitting to the right side of the bed. The bed was between the wheelchair and the nightstand. The call bell was tucked away on the top drawer of the nightstand to the left and away from residents reach. The resident is alert and oriented. In his neck is a trach stoma, a surgical opening on the neck to facilitate breathing. An oxygen (o2) humidifier was attached to the trach site. The resident can only mouth words and has weaknesses to the right side. The surveyor requested to speak with the resident's nurse.On 4/14/2026 at 11:22 AM In an Interview with the residents nurse a License Practical Nurse (LPN) #25. She was asked how the resident calls for help and she said that resident can use the call bell. She was asked where the call bell was, she saw it left inside the resident's nightstand top drawer. LPN #25 said that whoever made residents bed that morning must have placed the call bell there. She was asked how Resident#12 who is non-verbal and wheelchair bound will be able to call for help in case of emergency if they are unable to reach the call bell. She said resident always have their call bell within reach and proceeded to pull the call bell out of the nightstand top drawer and place it on the resident's bed within reach. She was made aware that this was a concern. She agreed that it was and said she will speak to the Staff about it. In an Interview with the Director of Nursing (DON) #3 on 4/16/2026 at 11:27 AM she was asked about the expectations regarding call bells. She stated that staff are expected to answer them within 5 minutes and make sure they always have them within reach of the residents. DON #3 was made aware of the above concerns; she acknowledged that it was a concern.

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	04/20/2026

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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 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. Based on observation and interview, it was determined that the facility failed to ensure residents and staff had a safe and comfortable environment. This was evident for 1 of 1 observation made in the facility laundry room.The findings include:On 04/17/2026 at 7:59 AM, an observation of the laundry room revealed a dryer closest to the wall in the laundry room, which had an exterior piece at the bottom that was leaning against the dryer.When the surveyor moved the exterior piece, it revealed parts of the dryer that lay below the area where items are placed to dry. Further observation of the laundry room revealed a portion of the wall to the right of the door prior to walking into the dirty laundry room from the clean laundry room which had a horizontal shaped hole in the wall, approximately 8 inches long and 2 inches wide.On 04/17/2026 at 8:03 AM, an interview with Laundry Aide (Staff #35) revealed she started at the facility about a month ago and the hole in the wall and lower part of the dryer noted above had been like that since she started.On 04/17/2026 at 10:03 AM, the surveyor reviewed the concern with the Nursing Home Administrator.