STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215347	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Park Rehabilitation and Healthcare Center	1525 North Rolling Road Catonsville, MD 21228

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interviews and medical record reviews, it was determined that the facility failed to implement a process to ensure residents receive written notice of room changes. This was evident for 1 (Residents #51) out of 1 resident, who expressed concern regarding room change notification during the recertification survey. The findings include: During an interview on 06/17/25 at 08:28 AM, Resident # 51 expressed concern that the facility had not provided written notification of roommate changes, and stated, this is a violation of my resident rights. During an interview with the Director of Nursing (DON) and Administrator on 06/17/25 at 09:15 AM, the surveyors were informed that although residents receive verbal notification of room changes, written notification is not provided. An example of verbal notification documentation was provided. The DON concurred that this practice did not meet the regulatory requirement for written notification.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview it was determined that the facility staff failed to report a resident eloped from the facility within the 2-hour allotted timeframe. This deficient practice was evidenced in 1 (#271) of 1 facility reported incident reviewed for an elopement during the recertification survey. The findings are: On 06/11/25 at 12:28 PM a review of the investigation of the facility reported incident (FRI) related to Resident #217 revealed the incident was reported to the state agency on 03/25/25 at 12:19 AM which was outside of the two-hour allotted timeframe to report the incident. The alleged incident occurred on 03/24/25 at 12:30 AM. The Administrator and Director of Nursing (DON) were made aware of the incident on 03/24/25 at 1:45 AM. On 06/11/25 at 12:52 PM during an interview with the Administrator he/she verbalized they follow the guidelines of the state agency regarding reporting incidents. They currently don't have a policy for reporting. The surveyor asked who is responsible for reporting incidents to the state agency. The Administrator and the Director of Nursing are responsible for reporting incidents to the state agency. Generally, when there was an allegation of abuse they would report the incident within a 2-hour window. Regarding the incident it would have been reported within a two-hour window, but the incident occurred at night when he/she wanted to get to the facility in a timely manner. Their goal was to get to the facility and ensure that the resident was safe.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interview, the facility staff failed to thoroughly investigate a complaint of abuse (Resident #120). This was evident for 1 out of 57 residents reviewed during a complaint/annual survey. Findings include: Review of Resident #120's facility reported incident (MD00178521) on 6/11/25 at 8:30 AM revealed the resident made an allegation of abuse after the resident reported to the facility that a nursing staff member pried medications out of the resident's left hand during a medication pass. An additional facility reported incident (MD00186277) on 6/11/25 at 8:40 AM revealed the resident made an allegation of abuse after the resident reported to the facility that a nursing staff member provided the resident with rough care when the nursing staff member dispensed nose drops. The surveyor requested the facility investigations for MD00178521 and MD00186277 on 6/11/25 at 9:00 AM. Interview with the Administrator on 6/11/25 at 11:30 AM revealed the facility did not have the facility investigations for MD00178521 and MD00186277. The Administrator stated that both of facility reported incidents occurred before the current administration. The surveyor pointed out that Centers of Medicare/Medicaid Services (CMS) policy states that the facility must keep the records of any facility reported incidents for at least 5 years after the investigation is closed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and observations, it was determined that the facility staff failed to adequately monitor a cognitively impaired resident who had exit seeking behaviors. This was found to be evident for 1 (#217) out of 2 residents reviewed for exit seeking behaviors during the recertification survey. This deficient practice was determined to be an Immediate Jeopardy past non-compliance after the investigation was completed. The findings include: A review of Resident #217 electronic medical record (EMR) on 06/11/25 revealed on 11/11/24 Resident #217 left their room located on the first floor and went to the front desk and attempted to leave the facility. After the attempted elopement, the resident was recommended to have a monitoring device placed to notify the facility staff if the resident attempted to leave the building. The elopement assessment dated [DATE] indicated the resident had a Wanderguard bracelet placed. On 06/11/25 at 11:48 AM a review of the facility's investigation related to the facility reported incident (FRI) #MD00216062 revealed on 03/24/25 at 12:30 AM the nursing staff on the second floor noted Resident #217 was missing. It was reported the resident was last seen by staff at 12:20 AM at the nurse's station. The Wanderguard system was alarming on the second floor, and the staff was unable to locate the resident within the facility or outside on the grounds; the police were notified. At 3:11 AM local authorities notified the facility staff the resident was found around Exit 17 towards Interstate 695. The resident was returned to the facility at 3:28 AM. The incident was reported to the state agency on 03/25/25 at 12:19 AM which was outside the two-hour allotted timeframe to report the incident. On 06/12/25 at 8:31AM during an interview with the Administrator the surveyor asked, how did Resident #217 get out of the building. The Administrator verbalized apparently he/she went out the front entrance. The wander guard pads did not go off; we determined that it was related to a power surge. The front door was ajar, and the system did not alarm. None of the staff heard the alarms. Our company determined that it was related to a power surge. During an interview with Maintenance Director #8 the surveyor asked what caused the front door to malfunction. Maintenance Director #8 verbalized a visitor could have pulled the door before the switch opened the door creating a short of the mag lock causing the door to malfunction. The surveyor asked if there was a visitor in the building at midnight. The Administrator verbalized visiting hours are not restricted. The surveyor asked if there was another power surge how they would ensure the residents' safety. Maintenance Director #8 verbalized if the door doesn't lock it would alarm. The staff would know the door was locked because it would not open. If the door won't open they can open it. The surveyor reviewed documentation that verified the front door was repaired on 03/26/25 and a Wanderguard system was applied to the elevator on 03/27/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the EMR revealed Resident #217 was wheelchair bound and had a facility acquired Stage III wound to his left heel and a right below the knee amputation (BKA). According to documentation in the resident's electronic medical record (EMR), the resident propelled their wheelchair with his/her left foot. On 03/20/25 the left heel wound measured 3.8 cm in length (L) x 1.6 cm width (W) x 0.3 cm depth (D). After the elopement there were no documented wound measurements in the EMR. The next documented wound measurements were taken over three days later 03/27/25; the measurements were 4.2 cm (L) x 2.0 cm (W) x 0.3 cm (D) which was a decline in the wound. On 06/18/2025 at 6:57 AM, the Administrator acknowledged the incident was a high-level concern. On 06/18/2025 at 12:55 PM, the surveyor verified all the facility staff were educated regarding elopement prevention on 03/29/25. The Administrator was made aware 03/29/25 was the Immediate Jeopardy (IJ) past non-compliance date. Three staff who worked on 03/29/25 during the 11:00 PM - 7:00 AM shift were educated about elopement policies including Wanderguard Management.

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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 medical record review and interviews it was determined that the facility staff failed to ensure a resident's medical record was accurate. This deficient practice was evident for 1 (#217) in 2 medical records reviewed for accuracy during the recertification survey. The findings include: On 06/11/25 at 12:19 PM a review of Resident #217's electronic medical record revealed the resident had a diagnosis of a complete traumatic amputation of the left lower leg. On 06/12/25 at 10:13 AM a review of Resident #217's skin assessment revealed the resident had a left heel wound. On 06/18/25 at 11:25 PM during an interview with the Administrator, the surveyor reported it was documented in the resident's electronic medical record that the resident had a complete traumatic amputation of the left lower leg, but it was documented on the wound progress report that the resident had a left heel wound. On 06/18/25 at 1:46 PM during an interview with the Administrator the surveyor asked who is responsible for ensuring the residents' diagnoses are entered correctly in the electronic medical record. The Administrator verbalized the admissions nurse enters medical information according to the discharge summary and the Minimum Data Set (MDS) Coordinator checks the accuracy of the medical information that was entered.