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	05/01/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review, the facility failed to ensure residents were treated with dignity and respect when staff publicly labeled residents as feeders on a dry erase board visible from the hallway and nurse's station. This practice compromised resident dignity, confidentiality, and privacy rights and affected Resident (R) #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35 and was observed during the complaint survey.Findings include:On 4/27/26 at 10:47 AM, 4/28/26 at 11:29 AM, 4/28/26 at 10:02 PM, 4/29/26 at 12:47 AM, and 4/30/26 at 10:05 AM, the surveyor observed a dry erase board located on the second floor next to the nurse's station. The board listed the above room numbers for Residents #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35 under a heading identifying the residents as feeders. The board was visible to staff, visitors, and anyone passing through the area, allowing resident care needs to be publicly disclosed.During an interview on 4/28/26 at 10:11 PM, GNA #15 stated that residents who are total care receive assistance with feeding and acknowledged the term feeders is used, although the staff member did not have any on the assignment.During an interview on 4/29/26 at 12:32 PM, GNA #8 stated that feeders refers to residents needing assistance with eating and acknowledged that staff should not refer to residents as feeders on the board due to privacy concerns.During an interview on 4/29/26 at 2:13 PM, GNA #11 stated that residents who require feeding assistance are identified by room number on the dry erase board and confirmed the sign is visible for everyone to see.During an interview on 4/29/26 at 3:07 PM, GNA #10 stated the dry erase board identifies feeders and their room numbers.During an interview on 5/1/26 at 10:15 AM, Unit Manager (UM) #26 stated staff should not refer to residents as feeders because it labels them and may make them feel incapable. UM #26 stated all would be in-serviced regarding appropriate terminology, including changing the terminology to assist with meals and emphasized that staff are expected to use appropriate, respectful language when referring to resident care.Record review on 5/1/26 at 10:41 AM of the facility's policy titled Dignity dated 2/21 documented: Staff speak respectfully to residents at all times, including addressing the residents by his or her name of choice and not ?labeling' or referring to the resident by his or her room number, diagnosis, or care needs.

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that an allegation of verbal abuse was reported and handled in accordance with Centers for Medicare and Medicaid Services (CMS) requirements for 1 (Resident #12) of 1 resident reviewed for abuse allegations during the complaint survey. The Findings include:Record review on 4/27/26 at 10:09 am revealed Resident #12 was admitted on [DATE] with diagnoses including dementia with behavioral disturbance, hemiplegia, HIV disease, dysphagia, and cognitive communication deficits.An examination of the Facility Reported Incident (FRI) on 4/30/26 at 2:30 pm revealed an anonymous allegation was received stating that Resident #12's, daughter was verbally abusive toward the resident. Per the FRI, staff and the Administrator became aware of the allegation on 10/31/25 at 10:00 am, contacted the local police department at on 10/31/25 at 10:05 am, reported the allegation to the resident's representative who was also the alleged perpetrator on 10/31/25 at 10:30 am, and the local Ombudsman's office on 10/31/25 at 11:12 am. The facility documented that the allegation was not verified, but the investigation was compromised by notifying the alleged perpetrator. There was no documentation that the facility protected the resident from potential retaliation during the investigation.During an interview on 5/1/26 at 10:57am, the Assistant Director of Nursing (ADON #3) stated that if the alleged abuser is in the building, we remove them but we don't tell them that they have an allegation of abuse against them, which contradicts the Administrator's actions.During an interview on 5/1/26 at 11:04 am, the Director of Nursing (DON #2) stated that when the alleged perpetrator is a family member, the facility tells them There is a reason to not let them in the building and that we don't say who the allegation is about, but acknowledged the Administrator may have done so.During an interview on 5/1/26 at 11:44 am, the Administrator stated that the resident's representative (the daughter) was notified of the allegation. The Administrator confirmed awareness that the resident's representative was the alleged perpetrator, stating: We let them know that the allegation of abuse is against them. We inform the guest that they are not allowed in the building. We provide enough information to get a statement. We would contact him/her to let them know that there was an allegation of abuse. The Administrator further stated that the representative was restricted from the building from the point we were made aware until we finalized the investigation. When the surveyor informed the Administrator that CMS regulations prohibit informing the alleged perpetrator of an allegation during the investigative process, as doing so may compromise the investigation and place the resident at risk, the Administrator stated he was unaware. Facility leadership confirmed this was standard practice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the clinical record was accurate, complete, and consistent for 1 (Resident #17) of 1 resident reviewed for an unexpected change in condition during the complaint survey. The findings include:During a record review on [DATE] at 12:27 pm, it was revealed that Resident #17 was admitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, obstructive sleep apnea, chronic kidney disease, and malnutrition.An examination of a progress note dated [DATE] at 9:36 am written by LPN#6, for Resident #17 on [DATE] at 1:25 pm indicated the resident expired on [DATE] following an early^morning change in condition. The change of condition was documented in the vital sign log dated [DATE] for oxygen saturations at 4:45 am, showing oxygen saturation at 60% and in the progress note the Licensed Practical Nurse (LPN #6) documented checking on the resident at 4:45 am and stated .Shortly afterward, during morning medication administration, the writer (LPN #6) approached the patient and found him/her unresponsive. A rapid assessment was performed, and at 5:52 am, CPR was initiated with the use of an AED. Emergency medical services were contacted at 5:53 am. EMS arrived at approximately 6:00 am and assumed resuscitation efforts. Despite continued attempts to revive him/her, the patient was pronounced deceased at 6:25 am.A record review on [DATE] at 12:01 am of Resident #17's physician's orders dated [DATE] reflected an order for Bi-level Positive Airway Pressure (Bi-PAP), which provided two different pressure levels, a higher-pressure during inhalation and a lower pressure during exhalation. The order specified use at bedtime and as needed for naps, with instructions to check placement and functioning when applied. LPN #6 documented that the resident had a Continuous Positive Airway Pressure (CPAP), which delivers one single, continuous level of pressure during both inhalation and exhalation.During an interview on [DATE] at 11:47 pm, LPN #6 stated Resident #17's oxygen saturation was 60% at approximately 4:45 am. The nurse stated the resident was not wearing his/her BiPAP at 11 pm, that there was no documentation of the refusal to wear the device, that the CPAP was applied around 1:00 am, and that after the phlebotomist drew blood, the nurse checked the oxygen saturation and blood sugar, offered fluids, and left the room. The nurse stated the resident was later found unresponsive.During a second interview on [DATE] at 6:40 am, LPN #6 again referenced the 60% oxygen saturation and stated Resident #17 had been active earlier in the shift with a nasal cannula and referenced a CPAP in place.During a third interview on [DATE] at 1:07 pm, conducted in the conference room with the survey team present, LPN #6 changed the account and stated Resident #17's oxygen saturation had been 90%, not 60%. The nurse stated they did not add a third liter of oxygen, contradicting prior interviews. The nurse also stated the oxygen concentrator was beeping and that they changed the resident from the concentrator to an oxygen tank. This information had not been previously reported and was not documented in the EMR. When asked why the concentrator alarmed, the nurse stated they were not a mechanic.During an interview on [DATE] at 3:11 pm, the Nurse Supervisor (RNS #21) stated LPN #6 approached her at approximately 5:55 am and reported the resident was unresponsive and that the nurse didn't know what was wrong. The supervisor stated the resident had no pulse and no respirations and was wearing a nasal cannula connected to an oxygen tank. The supervisor stated LPN #6 did not report any prior low oxygen saturation, alarms, or equipment issues. The supervisor also stated they were unable to reach the on-call provider and contacted the medical director, which was also not documented.During an interview on [DATE] at 11:35 am, the provider (MD #22) stated they were not notified of any change in condition prior to being informed that the resident had expired.During an interview on [DATE] at 11:25 am, the contracted laboratory's Chief Operating Officer stated the phlebotomist drew blood at 4:39 am and that a facility staff member accompanies the phlebotomist to verify identity. There was no documentation in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMR of the nurse's presence, assessment, or any postˆphlebotomy monitoring.During an interview on [DATE] at 11:04 AM, the Director of Nursing stated documentation is expected to reflect what staff observed and did. The DON stated that if the EMR entry dated/time' was corrected it would look like a falsification and that a 60% oxygen saturation would represent a significant change in condition requiring immediate intervention, which was not documented.

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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 observations, interviews, clinical record review, and review of facility policy, the facility failed to maintain an infection control program that would prevent and protect residents from the risk of infection for two (2) (Resident #14 and Resident #15) of 35 sampled residents reviewed during the complaint survey.The findings include: Review on 5/1/26 at 11:15 AM of the facility's Enhanced Barrier Precautions policy dated 2001 (Med-Pass) noted 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when.b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained.7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). B. Personal protective equipment (PPE) is changed before caring for another resident.8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care).16. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. Review on 4/28/26 at 3:00 PM of R#14's clinical record revealed the resident was admitted into the facility on 4/16/26 with diagnoses of a fracture of unspecified part of neck of right femur, muscle wasting and atrophy, chronic kidney disease and acute pulmonary edema. Observation on 4/27/26 at 12:04 PM revealed Geriatric Nursing Aide (GNA) #7 threw away a bag of trash outside of R#15's room door. There was an Enhanced Barrier Precaution sign posted on the door. GNA #7 was not wearing personal protective equipment (PPE) when they threw the material away in the trash can. Without hand hygiene and without putting on PPE, GNA #7 returned to the resident's bedside to continue providing care behind the privacy curtain in the room. At 12:22 PM, GNA #7 completed the task of assisting R#15 in getting dressed and transferring from their bed to their wheelchair. GNA #7 did not put on required PPE while assisting R#15 in getting dressed and transferring. Observation in R#14's room on 4/27/26 at 12:25 PM revealed Occupational Therapist (OT) #12 worked with R#14 in completing exercises of the bilateral upper extremities. OT #12 instructed the resident to lift weights for a set of 10. OT #12 placed their hands on R#14's bare arm and assisted the resident in completing sets of 10. OT #12 and R#14 had skin-to-skin contact. Observation on 4/28/26 at 9:56 PM revealed GNA #14 was providing care to R#14 behind a privacy curtain in the resident's room. There was an Enhanced Barrier Precaution sign posted on the door. The aide's feet were seen walking from one side of the resident's bed to the other. At 10:00 PM, GNA #14 walked from behind R#14's privacy curtain and removed their gloves and threw the gloves away in the trash. GNA #14 was not wearing a PPE as required for EBP. In an interview on 4/27/26 at 12:30 PM, GNA #7 was asked what type of PPE was required for EBP as posted on Resident #15's door. The aide said that PPE was required when providing direct care to residents. GNA #7 said that they were wearing a gown, gloves, and a mask earlier when they assisted the R#15 with a bed bath; however, the aide confirmed they did not put on the required PPE when they assisted the resident in getting dressed and transferring them to their wheelchair. During an Interview on 4/27/26 at 12:36 PM, OT #12 confirmed the therapist was working with Resident #14. During the interview, the therapist said that PPE was not required when working with R#14 because the resident had a catheter and the therapist did not have to come in contact with any bodily fluids. The therapist acknowledged he/she touched R#14 to assist them in lifting the weights during the exercises. OT #12 said that they sanitized their hands before and after working with the resident but did not wear (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PPE.In an interview on 4/28/26 at 10:02 PM, GNA #14 confirmed that they were changing R#14's brief after the resident had a bowel movement and confirmed that he/she were not wearing a gown during the incontinent care procedure. When asked what type of PPE was required for incontinent care for residents on EBP, GNA #14 said a gown and gloves were required. GNA #14 said that he/she usually wore a gown. In an interview on 4/29/26 at 12:31 PM, GNA #8 said that for EBP, staff were to put on gloves and gowns when providing direct contact care to residents. GNA #8 said that ?washing and dressing' a resident were examples of high contact care. Interview on 4/29/26 at 1:28 PM with GNA #9 revealed that staff were to wear gown, gloves and mask for EBP to protect the resident from potential infection. GNA #9 said that EBP were to be used for skin-to-skin contact when providing resident care. In an interview on 4/29/26 at 3:06 PM, GNA #10 said that EBP included hand hygiene when going into and out of a resident's room; and required wearing gloves and a gown each time staff provided care. Review on 5/1/26 at 10:50 AM of R#14's Physician's Order dated 4/27/26 revealed R#14 had orders for EBP due to the resident's indwelling catheter and wound. During an interview on 5/1/26 at 11:04 AM, the facility's Director of Nursing (DON) said that staff should wear gloves and gown when providing high contact care to residents with Enhanced Barrier Precautions. The DON said that included when therapy staff provided skin-to-skin contact and support during therapy services.