STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215362	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Restore Health Rehabilitation Center	4615 Einstein Place White Plains, MD 20695

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 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 clinical record review, staff interviews and an investigation into a complaint, it was determined that the facility failed to report an allegation of suspected resident abuse to the Office of Health Care Quality (OHCQ). This finding was evident for 1 (#166) of 2 residents reviewed for abuse during the annual survey. This finding is related to complaint #MD00185506. The findings include: The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse are to be reported to the Office of Healthcare Quality in a timely manner. A review of complaint intake MD00185506 on 6/30/2025 revealed that on 11/10/2022, Resident #166 alleged that staff members washed him/her in a rough manner while providing assistance with activities of daily living (ADL) care. A review of Resident#166's clinical record on 06/30/2025 at 11:18AM revealed a nursing progress note dated 11/10/2022 at 2:02 PM which stated Resident refused to be changed by two aides this shift. S/he stated that s/he does not want to be abused. GNAs made writer and ADON aware. Further record revealed a nursing progress note dated 11/10/2022 at 4:13 PM which stated, Resident observed to be combative and physically abusive towards staff during care, patient was offered a shower by a staff members, two therapy staff and two nursing assistant, patient consented to the shower, patient was transfer from bed to the shower chair by 4 staff member with a Hoyer lift, during the shower process the above patient started punching and hitting on staff, throwing towels with feces on it, the shower was stop, patient was dried up by staff and transfer back to bed safely, the police was called in, patient refused to talk to the police officer regarding the allegation of been physically abusive to the staff, patients medicated for pain with Tylenol 650mg x1 for pain.call place to the responsible party about patient aggressive behavior towards staff, refusing therapy services, P.O.A verbalized understanding of the patients behavior, writer request for a psych consult request as per MD order and RP consented On 6/30/2025 at 2:05 PM, the surveyor requested the facility's investigative record regarding the incident that occurred with Resident #166 on 11/10/2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 6/30/2025 at 2:22PM, the Administrator stated that she was unable to locate an investigative file related to the incident that occurred with Resident #166 on 11/10/2022. When asked if the allegation of abuse was reported to OHCQ, the Administrator stated, I'm not sure if it was reported to the state because I was not here at that time, but I can look into it and get back to you. During a follow up interview with the Administrator on 6/30/2025 at 2:52 PM, theAdministrator was not able to confirm that the allegation of abuse made by Resident #166 on 11/10/2022 was reported to the OHCQ. The Administrator further stated that it is the expectation that the facility reports all allegations of abuse to OHCQ in a timely manner. At the time of exit interview, the facility did not provide any additional evidence that the OHCQ was notified of Resident #166's allegation of abuse on 11/10/2022.

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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 facility staff interview and surveyor record review it was determined that the facility failed to investigate an alleged violation of abuse. This finding was found to be evident in 1 (Resident #187) out of 1 Resident that was reviewed for investigation of an alleged violation of abuse. The findings include: The Office of Healthcare Quality (OHCQ) received a facility reported incident (FRI)/self-report on 6/29/2023 at 8:56 AM from the facility's Assistant Director of Nursing (ADON) for an allegation of Resident abuse (family to Resident) - Intake#MD00193872. Resident #187 was linked to the Intake#MD00193872. The surveyor requested the facility investigation file for the facility reported incident (FRI) for Resident #187 on 6/17/2025 at 7:15 AM from the Licensed Nursing Home Administrator/ED (LNHA/ED). In an interview with the Licensed Nursing Home Administrator/Executive Director (LNHA/ED) on 6/17/2025 later in the day, she stated that she was unable to locate an investigation file for this facility reported incident (FRI) for Resident #187, but that she would continue to look for the investigation file. In a follow-up interview with the LNHA/ED on 6/23/2025 at 4:15 PM she stated she would have the company's IT/IS Department see if they were able to locate the self-reports in her email file for Resident #187. The surveyor conducted a record review of Resident #187's closed electronic medical record on 6/25/2025. Review of the medical record revealed a progress note written on 6/28/2023 at 4:54 PM by a licensed nurse which indicated that Resident #187's son was visiting Resident and yelled at him/her to stop screaming and then he/she left the facility. Additionally, there was a progress note written on 6/29/2023 at 5:16 PM by Social Services which indicated that Resident #187 responded no then yes when asked if his/her son grabbed his/her face and the Resident responded yes when asked if he/she felt safe. The surveyor reviewed on 6/25/2025 at 2:55 PM the facility's policy for Abuse, Neglect, and Misappropriation of Property dated 10/23/2019. The policy indicated that the facility collects, retains, and safeguards all information and evidentiary material pertinent to the investigation of the alleged abuse or neglect. The LNHA/ED provided the surveyor on 6/26/2025 with the initial self-report and final self-report for the facility reported incident (FRI) for 6/29/2023 that the company's IT/IS Department was able to locate in the LNHA/ED's email account. However, the facility was unable to produce an investigation file of the alleged violation of abuse (family to Resident) for Resident #187. No additional information was provided by the facility at the time of exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility staff interviews and surveyor review of a facility reported incident and a complaint, it was determined that facility failed to provide written notice to the Office of the State Long Term Care (LTC) Ombudsman of a Resident's discharge, and failed to ensure that a discharge summary was completed by a Resident's physician. This finding was found to be evident for 2 (Resident #62 and #171) out of 3 residents reviewed for discharge process during the annual survey. The findings include: 1. On [DATE] at 12:15 PM, a review of Resident #62's clinical record revealed that Resident #62 was admitted to the facility on [DATE] and discharged home on [DATE]. Further review of Resident #62's electronic clinical record revealed no documentation that the local ombudsman was notified of the resident's discharge from the facility. On [DATE] at 03:01 PM, an interview conducted with the Administrator revealed that discharge notices are sent to the ombudsman via email each time a resident is transferred to hospital by the Admissions Director #6. On [DATE] at 03:10 PM, an interview conducted with the Admissions Director #6 confirmed that an email is sent to the ombudsman each time a resident transfers / discharges to the hospital, however the Admissions Director #6 was unable to confirm that the ombudsman is notified when a resident discharged to home. On [DATE] at 03:23 PM, a review of the facility provided documentation of transfer/discharge notices sent the ombudsman via email from [DATE] to [DATE] was conducted by the surveyor. The review did not reveal any evidence that the ombudsman was notified of Resident #62's discharge to home on [DATE]. On [DATE] at 11:55 AM, an interview conducted with Regional Clinical Nurse #5 revealed that she could not locate any evidence that a written notice of discharge was given to the local ombudsman for Resident #62's discharge to home on [DATE]. At the time of exit conference, the facility did not provide any evidence that a written notice of discharge was given to the local ombudsman for Resident #62's discharge to home on [DATE]. 2. On [DATE] at 7:15 AM the surveyor conducted an investigation of a complaint (MD#00193420) that was received at the Office of Healthcare Quality (OHCQ) on [DATE] at 15:07 PM. The complainant alleged that Resident #171 was found unresponsive by the nursing staff, and it was unknown if a physician was present to determine the Resident's status at the time. The complainant alleged that the cause of Resident #171's death was unknown at that time. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Orders for Life-Sustaining Treatment (MOLST) is a program designed to improve the quality of care for patients with serious illnesses by translating patient preferences into medical orders that can be followed across different healthcare settings. The MOLST helps ensure that a patient's end of life wishes are honored by providing clear, portable medical orders that guide healthcare providers. The key aspects of the MOLST focus on patient preferences, portable and standardized, specific medical orders, collaboration and communication, and not a replacement for other advance directives. The surveyor conducted a record review of Resident #171's closed electronic medical record. Review of the medical record revealed that there was a progress note from the nursing staff that indicated that Resident #171 was observed unresponsive, no pulse at 7:07 PM on [DATE] by the nursing staff. The physician was notified via phone by the nursing staff and the physician pronounced Resident #171 deceased . Further review of the medical record revealed that Resident #171 had a MOLST which indicated that Resident was Do Not Resuscitate (DNR) status. In an interview on [DATE] at 8:00 AM with the Director of Nursing (DON) the surveyor asked what the expectation was for physician documentation of a death in the facility. The DON stated that the expectation was that a progress note/discharge note was to be completed by the physician that pronounced the Resident. The surveyor conveyed to the DON that there was not a progress note/discharge note in Resident #171's medical record. The only progress note was from the nursing staff and there was a Record of Death and Mortician's Receipt form from Maryland Cremation Services which indicated that the remains was released from the facility and received by the mortician. The surveyor interviewed the Medical Records Coordinator (MRC) at 10:15 AM on [DATE]. The surveyor conveyed to the MRC that there was not a physician progress note/discharge note for Resident #171. The MRC acknowledged the surveyor and stated that there should be a discharge summary/progress note from the physician and that she had contacted the Maryland Cremation Services for a death certificate. In a follow up interview later that day with the Medical Records Coordinator (MRC) on [DATE] she stated that she was waiting for the death certificate as she had sent an email to Maryland Cremation Services requesting the certificate. Additionally, the MRC stated that the physician that pronounced Resident #171 on [DATE] was no longer employed with Adfinitas Health-Physician Services as of [DATE]. The surveyor received a copy of the death certificate via email from the facility on [DATE].

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined the facility failed to initiate wound care upon admission for a Resident with Pressure Ulcers. This was evident for 1 (Resident #191) out of 4 residents reviewed for pressure ulcers during the survey. The findings include: A pressure ulcer (also known as pressure sore or decubitus ulcer) is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), and Stage IV (full thickness skin loss with extensive damage to muscle, bone, or tendon). Deep Tissue Injuries (DTIs) are characterized by intact skin that is discolored (purple or maroon) or a blood-filled blister, indicating damage to underlying soft tissue due to pressure or shear. DTIs are considered unstageable pressure injuries until the wound fully evolves and can be numerically staged. During a review of Compliant #MD00203067 for Resident #191 on 6/24/25 at 12:56 PM it revealed, after just one week under their care, he/she developed bedsores and blisters across his/her body. During a medical record review on 6/24/25 at 1:06 PM for Resident #191 it was discovered that the Resident was admitted on [DATE] at 6:14 PM. The Discharge/Transfer summary from the transferring hospital reported Resident #191 had a right thigh decubitus in clean dressing and the Hospital Discharge Diagnosis/Plan stated, Decubitus lesion, Continue wound care. During continued review of the medical records for Resident #191 it was discovered that the Observation Report for admission was completed on 2/16/24 at 7:33 PM and the skin assessment identified a Bruise right upper arm. A Nursing progress note written on 2/17/2024 at 12:41 AM reported A head-to-toe examination revealed dry skin, a dry scar on the right foot, and a nonbleeding bruise on the right forearm. No open wound was noted. During additional medical record review it was revealed that physician orders were added for wound care for Resident #191 on 2/19/24 at 4:47 PM. The orders included: wound treatment: Location bilateral heel, Apply skin prep Twice a day, Right upper thigh, clean with wound cleanser, apply hydro gel and cover with boarded gauze twice a day and Sacral wound, clean with wound cleanser, Apply Medi honey and cover with boarder gauze. It was discovered that the Resident had no wound care documented prior to these orders. During further medical record review for Resident #191 it was discovered that a Nursing Progress note written on 2/19/24 at 9:54 PM stated, Please note the following addendum to the admission note: Upon further examination, a DTI of 1.7 x 2 was indicated on the resident's right lateral foot, with an additional area of 1.5 x 1.2 on the middle of the foot and an area of 6 x 4 cm on the right heel. Also, a DTI of 1.1 x 1.3 has been noted on the left lateral foot. In addition, the resident has an open wound measuring 7 x 2 cm with dry blisters measuring 6 x 2 cm on the right upper thigh and an open wound of 1.2 x 1 cm on the sacrum, including the left ischium DTI of 6X2.2cm. An order has been placed to manage the skin and monitor the wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an additional medical record review for Resident #191 a Wound Management Detail report dated 2/22/25 was discovered and the following wounds were documented as being present upon admission: DTI - Right big toe, DTI - Left big toe, Trauma - Right Buttock Right Ischium, Pressure Ulcer - Sacrum Stage 3, a DTI - Right top of foot and to the right lateral foot. During an interview with the Director of Nursing (DON) on 6/27/25 at 11:50 AM she reported the Resident would get a head-to-toe assessment upon admission and if any bedsores are found they should be documented, assessed, treated and redressed if necessary. She advised any wound care provided to the Resident should have been documented in the Resident's medical record. She reported treatment for the wounds should have been started earlier because the goal is to catch it before it gets worse. She is not sure what may have caused the delay in wound care because she was not working in the facility at the time Resident #191 was a Resident. During an interview with the Unit Manger for the [NAME] Oak Unit on 6/30/25 at 10:07 AM it was discovered that upon admission nursing staff should perform a head-to-toe skin assessment and if any issues are found the doctor should be notified. She confirmed that pressure ulcers are a reason for the doctor to be notifed. The doctor would provide orders and care for the pressure ulcers should start care as soon as orders are obtained. She advised she is not sure what the wound care delay would have been for Resident #191 because she wasn't working at the facility at that time; however, she believes care should have started sooner.