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

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, observation and interview, it was determined that the facility staff failed to provide privacy to a resident during the administration of a subcutaneous injection. This was evident in 1 (Resident #54) of 1 resident observed for injection administration. The findings include: A review of Resident #54's clinical record revealed that the resident was admitted to the facility with diagnoses including Dementia and Diabetes Mellitus. On 06/16/2025 at 10:10 AM the surveyor observed Registered Nurse (RN) #2 administer medications to Resident #54. The medications included Heparin 5,000 units to be administered by subcutaneous injection twice a day. During the observation, RN#2 failed to provide privacy to the resident while administering the Heparin injection. After going into Resident #54's room, RN#2 did not close the door or pull the privacy curtain. RN#2 informed the resident that she was going to administer a Heparin injection, then pulled up the resident's hospital-type gown and administered the injection to the right side of the resident's abdomen. In an interview during the medication observation, the surveyor enquired about the practice for providing privacy during injection administration. RN #2 confirmed that she did not provide privacy by pulling the curtain or by closing Resident #54's door. RN #2 stated I apologize, I should have provided privacy. On 06/26/2025 at 07:52 AM in an interview with the surveyor, the Director of Nursing stated that staff members are required to provide privacy to residents during injection administration. She stated that if a resident is in a private room, the door should be closed and if the resident was in a semi-private room the curtain should be drawn. The surveyor informed the DON of the findings during the observation of a Heparin injection administration.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff and Residents and surveyor record review it was determined that the facility failed to develop and implement comprehensive care plans for Residents. This finding was found to be evident for 4 (Resident #21, #51, #54, and #61) out of 7 Residents reviewed for the development and implementation of comprehensive care plans. The findings include: 1. In an interview with Resident #51 on 6/16/2025 at 11:49 AM, the Resident stated that he/she had one fall in the bathroom a few weeks ago. The Resident stated that he/she had pain in both knees and received pain patches for the knee pain. The surveyor conducted a record review of Resident #51's medical record on 6/18/2025 at 11:15 AM. Record review revealed a progress note that Resident #51 had a fall on 5/27/2025 at 4:00 PM when Resident attempted to transfer self from toilet to wheelchair and lost balance. Additionally, review of Resident #51's care plan revealed that Resident did not have a comprehensive care plan developed or implemented for the actual fall on 5/27/2025, however, there was a plan of care for at risk for falls. In an interview with the Director of Nursing (DON) at 1:40 PM on 6/18/2025 the surveyor conveyed that Resident #51 had a fall on 5/27/2025 and the incident report and the fall investigation that were provided by the DON substantiated the fall on 5/27/2025. Further review of Resident #51's care plan on 6/23/2025 at 11:00 AM revealed that a plan of care time stamped 6/18/2025 at 2:28 PM for an actual fall was now included in Resident's comprehensive care plan after surveyor intervention. 2. The surveyor conducted a record review of Resident #54's medical record on 6/23/2025 at 11:05 AM. Resident #54 was admitted to the facility on [DATE] at 7:43 PM for short term rehabilitation. Review of the medical record revealed that Resident #54 had physician orders for two medications Furosemide (Lasix) which was a diuretic medication and Quetiapine (Seroquel) which was an anti-psychotic medication. Further review of the Resident #54's medical record revealed that the care plan was not reflective of the Resident receiving these two medications. Resident #54 had been receiving Seroquel at home and Lasix was ordered on 6/5/2025 at the facility. There was not a plan of care developed or implemented for Lasix and Seroquel for Resident #54. In an interview with the RN MDS Coordinator #3 at 12:15 pm on 6/24/2025 the surveyor asked who was responsible for the development/implementation of comprehensive care plans for the Residents and the RN MDS Coordinator stated that the nursing staff were responsible for the Resident care plans. The surveyor conveyed to the RN MDS Coordinator that Resident #54 had physician orders for Seroquel and Lasix but there were no care plans to address either of these two medications. The RN MDS Coordinator acknowledged the surveyor and stated that she would share this information with the staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:45 PM on 6/26/2025 the surveyor reviewed the care plan concerns with the Regional Nurse, Director of Nursing (DON) and the Licensed Nursing Home Administrator/Executive Director (LNHA/ED) and they acknowledged the surveyor. No additional information was provided by the facility. 3. A nasal cannula is a device used to deliver oxygen to a resident, it consists of a flexible tube that is placed under the nose and has two prongs that go inside the nostrils to deliver oxygen. During an observation on 6/16/25 at 11:11 AM Resident #61 was observed lying in bed with oxygen being administered by a nasal cannula. During a medical record review for Resident #61 on 6/16/25 at 12:45 PM it was discovered he/she was admitted on [DATE] and required oxygen to assist with breathing. The initial orders for the resident after being admitted to the facility included Oxygen at 2 liters per minute via nasal cannula every shift and Observe for any symptoms of SOB or trouble breathing every shift. During a continued review of the Resident's medical records, it was discovered that the Resident had an order for Eliquis, an anticoagulant, to be taken twice daily. The Resident's Medication Administration Record (MAR) revealed that Eliquis had been administered twice daily since 6/05/25. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. During a review of the Minimum Data Set (MDS) for Resident #61 it was found that based on the Assessment Reference Date of 6/08/25 the Resident was identified as having shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. It also identified the resident required oxygen and had been taking an anticoagulant. During further review of the Resident's medical records, it was determined that Oxygen and anticoagulant medication had not been included in the Resident's Care Plan. During an interview with the Director of Nursing (DON) on 6/17/25 at 1:28 PM she reviewed the chart for Resident #61 and confirmed that oxygen and Eliquis were not included in the Resident's Care Plan. She agreed they should have been included in the Care Plan. During a review of the Care plan for Resident #61 on 6/17/25 at 3:26 PM it was discovered that the Care Plan was updated on 6/17/25 at 1:38 PM with the Resident requires oxygen therapy related to COPD and Potential for complications related to anticoagulant therapy. 4. During a review of the Medical Records for Resident #21 on 6/23/25 at 12:10 PM it was discovered that he/she had a history of diabetes. A review of the Medication Administration Record (MAR) revealed the Resident was taking insulin for diabetes, the medications included a Novolog Flexpen Insulin which was started on 12/26/24 and an Insulin Glargine insulin pen which was started on 2/04/25. It was also found that the Resident was taking Clopidogrel, an anticoagulant, which was started on 4/30/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan is used in nursing facilities to summarize a resident's health conditions and care needs. It is used to ensure resident's needs are met and consistent care is provided to the resident based on those needs. During a continued review of the Resident's medical records on 6/23/24 at 2:46 PM it was determined that Diabetes, Insulin administration and anticoagulant medication were not included in Resident #21's Care Plan. During an interview with the Director of Nursing on 6/23/25 at 2:50 PM she confirmed diabetes, insulin and the anticoagulant were not in Resident #21's care plan but should've been and advised it's not updated. She reported, We need some work on care plans. During a medical record review for Resident #21 on 6/24/25 at 7:51 AM it was discovered that the Care Plan was updated on 6/23/25 with Resident is taking clopidogrel for prevention of thrombotic events, placing them at increased risk for bleeding and Resident has insulin-dependent diabetes mellitus related to impaired glucose metabolism.

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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 observation, interviews with Residents and staff and surveyor record review it was determined that the facility failed to ensure that Resident's care plans were revised and updated timely. This finding was found to be evident in 2 (Resident #51 and #54) out of 2 Residents reviewed for care plan timing and revision. The findings include: The surveyor toured the nursing unit on 6/16/2025 at 8:44 AM and observed Resident #51 in his/her room in the wheelchair. The Resident stated that he/she had a fall in the bathroom when he/she attempted to transfer from the toilet to the wheelchair and lost balance and had pain in both knees a few weeks ago. A record review was conducted by the surveyor on 6/18/2025 at 11:15 AM of Resident #51's medical record. Record review of the progress notes revealed that Resident #51 had a fall on 5/27/2025 at 4:00 PM when Resident attempted to transfer self from toilet to wheelchair and lost balance. Bilateral knee x-rays were performed which revealed no fractures. Additionally, review of Resident #51's care plan revealed that Resident had a care plan for at risk for falls but not a care plan for an actual fall, and there was not an intervention added to the care plan when the Resident had the fall on 5/27/2025. In an interview with the Director of Nursing (DON) at 1:40 PM on 6/18/2025 the surveyor conveyed that Resident #51 had a fall on 5/27/2025 and the incident report and the fall investigation that were provided by the DON substantiated the fall on 5/27/2025. Additionally, the surveyor conveyed that there was not an intervention added to the care plan when Resident #51 had the fall on 5/27/2025 at 4:00 PM. Further record review of Resident #51's care plan on 6/23/2025 at 11:00 AM revealed that a plan of care time stamped 6/18/2025 at 2:28 PM for an actual fall was now included in Resident's care plan. Resident #51's care plan was updated to reflect an actual fall after surveyor intervention. An MDS assessment nurse, also known as a nurse assessment coordinator, is a Registered Nurse (RN) who specializes in the Minimum Data Set (MDS) assessments for Residents in nursing homes and other long-term care facilities. They play a crucial role in ensuring accurate and timely assessments, which are essential for Resident care planning, facility funding, and regulatory compliance. In an interview with the RN MDS Coordinator #3 at 12:15 pm on 6/24/2025 the surveyor asked who was responsible for the update and revision of Resident care plans and the RN MDS Coordinator stated that the nursing staff were responsible for updates and revisions to the Resident care plans. A Foley catheter is a thin, flexible tube inserted into the bladder to drain urine. It's also known as an indwelling urinary catheter and is held in place by a small balloon inflated inside the bladder. Foley catheters are used for various reasons, including urinary retention, incontinence, and after certain surgeries, and they allow for continuous urine drainage into a collection bag. (continued on next page)

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	215362	A. Building B. Wing	06/30/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On tour of the facility on 6/16/2025 at 8:44 AM the surveyor observed Resident #54 in bed with a Foley catheter drainage bag attached to the frame of the bed. The Resident stated that he/she has the catheter for edema. The surveyor conducted a record review of Resident #54's medical record on 6/23/2025 at 11:05 AM. The record review revealed that Resident #54 had a physician order for an indwelling Foley catheter for urinary retention as of 6/13/2025. Further review of the medical record, specifically the care plan revealed that there was not a plan of care for the indwelling Foley catheter. In an interview with the RN MDS Coordinator #3 on 6/24/2025 at 12:15 PM the surveyor conveyed that Resident #54 had an indwelling Foley catheter in place since 6/13/2025 but there was not a care plan for the catheter. The RN MDS Coordinator acknowledged the surveyor. At 3:45 PM on 6/26/2025 the surveyor reviewed the care plan concerns with the Regional Nurse, Director of Nursing (DON) and the Licensed Nursing Home Administrator/Executive Director (LNHA/ED) and they acknowledged the surveyor. No additional information was provided by the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review it was determined that the facility failed to ensure that the posted nurse staffing information was accurate and current. This finding was found to be evident in the review of sufficient and competent Nurse staffing. The findings include: The facility's staffing data document may be a form or spreadsheet, and all the required information displayed clearly and in a visible place. The information should be displayed in a prominent place that was readily accessible to residents, staff, and visitors and presented in a clear and readable format. This information posted must be up-to-date and current. The facility must post the nurse staffing data on a daily basis at the beginning of each shift. The facility must ensure staffing information was accurate and current. At 1:20 PM on 6/18/2025 the surveyor observed in the facility lobby on the receptionist desk the posted nurse staffing information in a clear standing frame. The date that was indicated on the posted nurse staffing information form was 6/17/2025. In an interview with employee #9 at 1:22 PM on 6/18/2025 she stated that the posted nurse staffing information form was posted daily by the Administrator-In-Training (AIT) employee #8. The surveyor conveyed to employee #9 that the date was incorrect on the posted nurse staffing information form. Employee #9 requested an updated nurse staffing information form from employee #8. Employee #9 posted on the receptionist desk the updated nurse staffing information form with the correct date of 6/18/2025. At 1:40 PM on 6/18/2025 the Director of Nursing (DON) was notified of the nurse staffing information form not posted on the receptionist desk with the correct date of 6/18/2025. The surveyor conveyed to the DON that the nurse staffing information sheet was posted but not with the correct date. The DON acknowledged the surveyor and stated, yes they told me about the incorrect date of 6/17/2025 and an updated nurse staffing information form was posted with the correct date of 6/18/2025.

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	215362	A. Building B. Wing	06/30/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews it was determined that the facility failed to store food in a manner that ensures food safety. This was evident in 1 out of 2 dining areas observed during the survey. The findings include: During an observation of the Refrigerator in the [NAME] Oak Dining Room on 6/16/25 at 8:12 AM there were food containers found that were expired and that had no name or date. These foods included: A disposable plastic food container for Resident #51 dated 6/11/25 A plate of salad without a date made or date placed into the refrigerator A plastic container of food with no name or date written on it Two containers with a room number but no date A plastic bag of food for Resident #61 with no date A plastic bag of food with no name or date During an interview with the Director of Dining Services on 6/16/25 at 8:18 AM he reported the refrigerator was for Residents to store food brought into the facility. He advised anything put into the refrigerator should be labeled fully with the name of the Resident and the date that the item was put inside. He reported items would be considered expired and thrown out after three days. He confirmed the food for Resident #51 should have been removed from the refrigerator and wasted. During a review of the facility's Nutrition Policies and Procedures: Food From Outside Sources, Safe Handling Of on 6/17/25 at 1:46 PM it stated that Foods are labeled to identify the patient/resident's name, container contents, and the date it was prepared and that Items will be stored for three days. Expired and unlabeled items will be discarded.

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	215362	A. Building B. Wing	06/30/2025

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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 Record Reviews, Observations and Interviews it was determined that the facility failed to ensure medical records were complete and accurate. This was evident for 2 (Resident #61, #46) out of 5 Residents reviewed for complete and accurate medical records. The findings include: 1. During a medical record review on 6/18/25 at 9:23 AM it was discovered that Resident #46 had an order for a Pressure relieving Mattress present on bed for skin integrity protection that was ordered on 3/28/25 and an Air Mattress for pressure relieving to wounds every shift that was ordered on 5/01/25. During a review of the Treatment Administration Record (TAR) for Resident #46 it was discovered that the order for the Pressure Relieving Mattress and the order for Air Mattress was documented as being completed from 6/01/25 to 6/20/25. During an observation of Resident #46 with LPN #16 on 6/20/25 at 10:52 AM she confirmed the Resident dId not have an air mattress but dId have a pressure relieving mattress. During an interview with the Unit Manager for the Sycamore Unit on 6/20/25 at 11:04 AM she confirmed that the Resident had orders for two different types of mattresses and was unsure which order should be followed. She advised the Air Mattress order was placed most recently so that was probably the correct order to follow, but she would investigate. During an interview with the Director of Nursing (DON) on 6/20/25 at 2:45 PM she reported the order for the Air Mattress should have been removed because after the order was placed, the family and physician decided to not use the Air Mattress. During a review of the TAR 6/23/25 at 9:23 AM it was discovered that the order for the Air Mattress was discontinued on 6/20/25. 2. During a medical record review on 6/18/25 at 10:54 AM it was discovered that Resident #46 had a physician order for Resident to be out of bed Mon-Wed-Fri for 1-2 hours that was placed on 6/09/25. During a continued review of the Resident's medical records it was discovered that the order did not transfer to the Resident's Treatment Administration Record (TAR). During an interview with the Director of Nursing (DON) on 6/20/25 at 2:45 PM she confirmed the order should appear on the TAR for nursing staff to see and sign off as completed. She reported the order wasn't put in correctly so it didn't transfer to the TAR and advised we will have to do some training on putting in orders. During a Record review on 6/23/25 at 11:29 AM it was found that the order was corrected and appeared on the TAR on 6/20/25. (continued on next page)

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	215362	A. Building B. Wing	06/30/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a medical record review for Resident #61 on 6/23/25 at 9:47 AM it was discovered that a Nursing Progress note was written on 6/21/25 at 7:17 AM which stated, Pain meds was given at 6:30 am. During a continued review of the Resident's medical records, it was discovered that the Medication Administration Record (MAR) had no documentation of any medications being administered during that time. The MAR showed the only medication administered for Resident #61 on the morning of 6/21/25 was Lorazepam at 9:00 AM and Morphine was given at 10:08 AM. During an interview with the Unit Manager from [NAME] Oak on 6/26/25 at 2:51 PM she reported medications should be signed off in the Medication Administration Record immediately after given. She confirmed there was no documentation of medications being given on 6/21/25 at 6:30 AM in the MAR for Resident #61. During an interview with the Director of Nursing on 6/26/25 at 3:01 PM she confirmed medications should be documented in the MAR when given and was unable to determine what medications were given to Resident #61 on 6/21/25. During a review of the Controlled Drug Receipt/Record/Disposition Form on 6/30/25 at 11:13 AM it was revealed that Resident #61 had a sign off sheet for Morphine and for Lorazepam. The Morphine Form showed the last two administrations were at 10:00 PM on 6/20/25 and at 9:00 AM on 6/21/25. The Lorazepam form showed the last 2 administrations were on 6/02/25 at 8:00 PM and 6/21/25 at 8:10 AM. There was no documentation for medication being administered at 6:30 AM on 6/21/25.

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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 record review, observation and interview, it was determined that the facility staff failed to perform hand hygiene during medication administration. This was evident in 1 (Resident #40) of 5 residents observed during medication administration. The findings include: A review of Resident #40's clinical record revealed that the resident was admitted to the facility with diagnoses including Hypertension and Myocardial Infraction. On 06/16/2025 at 09:45 AM during a medication administration observation, the surveyor observed Registered Nurse (RN) #2 take Resident #40's Blood Pressure. RN #2 reported the Blood Pressure as 137/80 then walked to the medication cart and wrote the Blood Pressure down on paper. RN #2 unlocked the medication cart and proceeded to dispense the resident's medication without performing hand hygiene. The surveyor intervened and asked about hand hygiene. RN #2 then performed hand hygiene using hand sanitizer solution. Later, at around 09:50 AM while RN #2 was dispensing medications, a visitor walked up to the medication cart. RN #2 conversed and shook hands with the visitor. After the conversation, RN #2 went back to the medication cart and continued to dispense medications without performing hand hygiene. When the surveyor pointed out the need for hand hygiene, RN #2 reached for a bottle of hand sanitizer which was on the medication cart and sanitized her hands. In an interview on 06/16/2025 during the medication pass, RN #2 confirmed the surveyor's observations, apologized and stated that she should have performed hand hygiene before handling the medications and after shaking the visitor's hands. On 06/26/2025 at 07:52 AM in an interview with the Director of Nursing (DON) regarding the process for medication pass, the DON stated that staff members are required to perform hand hygiene before and after taking care of a resident and after leaving a resident's room. Also, staff members are required to perform hand hygiene before touching the medication cart to dispense medications. In addition, hand hygiene should have been performed by the staff member after shaking the visitor's hand. The DON was notified of the surveyor's findings.

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	215362	A. Building B. Wing	06/30/2025

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, it was determined that the facility failed to maintain a functional and sanitary environment. This was found evident in 1 out of 2 dining areas observed during the survey. The findings include: During observations on 6/16/25 at 8:14 AM it was discovered that a non-operating ice and water dispenser was on top of the counter in the Sycamore Café. Further observation revealed the cabinet below the dispenser was missing the handle to the right door. The floor inside the cabinet was broken into pieces and crumbled in the center. The interior of the cabinet had brownish stains running down the walls and on the broken flooring. A broken pipe was found inside the cabinet. During an observation and interview with the Director of Maintenance on 6/17/25 at 2:12 PM he reported that he had been employed with the facility for about four and a half months. He advised he was not aware of the damaged cabinet and described the crumbled flooring as pressed wood. During an interview with the Administrator on 6/17/25 at 2:21 PM she advised the cabinet had been like that for a while. She added we are planning on fixing it, it's a process, it's a big expenditure. During an observation on 6/30/25 at 8:47 AM it was discovered that the cabinet floor had been replaced, and the interior of the cabinet had been cleaned. The non-operating dispenser remained on the cabinet, the doors to the cabinet were lopsided and the handle to the right door remained absent.