

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER Forestville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7420 Marlboro Pike Forestville, MD 20747	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and interviews it was determined the facility failed to investigate and take appropriate action to further prevent abuse. This was evident during the surveyor's review of facility reported incident #2635881 for Resident #2. The findings include: Resident #2's medical record review on 10/30/2025 at 9:24 AM revealed a care plan focus that Resident #2 had history of attempting to touch female staff and resident, attempting to go to female residents room and touching female residents inappropriately with interventions dated 11/03/2022 that staff were to monitor resident while in the room, redirect resident at all times and educate resident to keep his/her hands to themselves. During review of the facility reported incident #2635881 on 10/30/2025 at 9:50 AM revealed that on 09/29/2025 Resident #2 was witnessed inappropriately touching Resident #1. The facility placed a caregiver (1:1) 24 hours a day, 7 days a week to ensure Resident #2 did not enter other residents' rooms as well as moved Resident #2 to another room. During an interview on 10/30/2025 at 10:00 AM the Director of Nursing staff #2 stated that Resident #2 had a 1:1 caregiver due to the substantiated allegation of abuse, the facility was looking to discharge Resident #2 to another facility and until he/she gets discharge will continue with a 1:1 caregiver 24 hours a day/ 7 days a week. During an interview on 10/30/2025 at 10:25 AM staff #26 stated that Resident #2 until he/she had a caregiver watching him/her had been going into other female resident rooms without supervision, touching residents and it was good that he/she had a caregiver now. During an interview on 10/30/2025 at 1:00 PM staff #9 stated that Resident #2 has had past behaviors of attempting to inappropriately touch, going into other residents' rooms of female residents prior to 09/29/2025. Review of resident #2's medical record on 10/30/2025 at 1:30 PM revealed several social worker progress notes dated from 12/5/2022 - 01/28/2025 indicating that Resident #2 had behavior problems of attempting to go into female rooms, and attempting to touch female staff and female residents.</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review it was determined the facility failed to ensure timely administration of medications, follow medical care orders, and follow professional standards. This was evident for 1 out of 1 Resident (Resident #24) reviewed for medication administration during the facility's complaint survey. The findings include: On 10/30/25 at 9:32AM the surveyor reviewed complaint 292569 which included concerns surrounding the timeliness of administration of important medications which included high risk medications. On 10/30/25 at 12:59PM the surveyor requested the medication administration audit report for Resident #24 from the facility's Director of Nursing. On 10/31/25 at 9:01AM the surveyor conducted a review of the facility's policy for liberalized medication administration. Review of that policy revealed: 1.) The medical Director will provide oversight and direction for the liberalized medication administration program, 2.) Medication parameters may be adjusted with approval of the medical director, 3.) Any medication ordered by the physician for a specific time will be given at that specific time, 4.) The general nursing standards of practice for medication administration will remain in place including the 5 rights of medication administration, 5.) Nurse should be familiar with medication administration requirements of high risk medications and contact the pharmacy, consultant pharmacist, or a drug reference when they are not sure if a medication has a specific timing requirement, 6.) Oral hypoglycemic medications generally have to be given 1/2 hr before meals or at the meal time, 7.) Insulin that has a swift onset of action will be given as close to the meal as possible for the before meals indication, or may be given at the beginning of the meal, 8.) Antibiotics will be scheduled times per physician orders, and 9.) Documentation of liberalized medication administration requires the same standards of documentation as required by regulations for medication administration. Further review of the policy revealed that for medications able to be liberalized, AM medication administration was defined as starting at 6:00AM and may extend to 11:00AM. and PM medication was defined as starting at 4:00PM and may extend to 7:00PM. Review of Resident #24's medication orders revealed both scheduled times were present for various medications as well as labeling of them on the medication administration record as AM, PM, etc. for both medications able to be liberalized and medications the policy identified as not being able to be liberalized. Review of the medication administration audit report on 10/31/25 at 11:21AM by the surveyor revealed that on the following dates medication was not timely administered to Resident #24: 1.) Losartan Potassium medication for Resident #24's hypertension was ordered with a scheduled time of 7:00AM with an administration time of 11:36AM on 12/25/24. 2.) Zinc Sulfate medication for Resident #24's wound healing was ordered with a scheduled time of 7:00AM with an administration time of 11:35AM on 12/25/24. 3.) Ascorbic acid medication for Resident #24's wound healing was ordered with a scheduled time of 7:00AM with an administration time of 11:36AM on 12/25/24. 4.) Ergocalciferol medication with a scheduled time of 7:00AM with an administration time of 11:35AM on 12/25/24. 5.) Carvedilol medication with a scheduled time of 7:00AM with an administration time of 11:36AM on 12/25/24. 6.) Metformin medication with a scheduled time of 7:00AM with an administration time of 11:35AM on 12/25/24. 7.) Ferrous sulfate medication with a scheduled time of 7:00AM with an administration time of 11:35AM on 12/25/24. 8.) Fluconazole medication with a scheduled time of 7:00AM with an administration time of 11:35AM on 12/25/24. 9.) Daptomycin intravenous solution medication for Resident #24's infection with a scheduled time of 7:00AM with an administration time of 1:21PM on 12/25/24. 10.) Monitoring of wound vac functioning and other care orders with a scheduled time for 3:00PM was observed with an administration time which was after the 3PM-11PM shift ended, at 11:11PM on 12/25/24, and monitoring every shift for wound vac functioning order with a scheduled time for 11:00PM on 12/25/24 was observed with an administration time which was after the 11PM-7AM shift ended, at 7:08AM on 12/26/24. 11.) Humalog insulin medication with a scheduled time of 4:30PM with an administration time of 8:49PM on 12/25/24. 12.) Sliding scale blood sugar check with a scheduled time of 4:30PM was documented as obtained at 8:49PM on 12/25/24. 13.) Losartan medication with a scheduled time of 7:00AM with an administration time of 11:06AM on 12/24/24. 14.) Ferrous sulfate medication with a scheduled time of 7:00AM with an administration time of 11:06AM on 12/24/24. 15.) Ascorbic acid medication with a scheduled time of 7:00AM with an administration time of 11:06AM on 12/24/24. 16.) Zinc sulfate medication with a scheduled time of 7:00AM with an administration time of 12:00PM on 12/24/24. 17.) IV PICC flush 10cc saline with a scheduled time of 7:00AM with an administration time of 11:58AM on 12/24/24. 18.) Daptomycin intravenous solution for Resident #24's infection with a scheduled time of 7:00AM with an administration time of 12:00PM on</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview it was determined the facility failed to follow professional standards for food service safety. This was evident during 1 out of 1 random observations made by the surveyor during review of complaint 292569. The findings include: On 10/30/25 at 9:32AM the surveyor reviewed complaint 292569 which included an allegation/concern for the way ice storage used for resident ice water was handled by facility staff. On 10/30/25 at 11:12AM the surveyor observed the facility's second floor nutrition room with an ice scoop holder on the wall which contained an ice scoop, however, the ice scoop was situated on top of and partially within a plastic bag which was observed stuffed within the ice scoop holder. On 10/30/25 at 11:19AM the surveyor observed an open metal cart which contained an ice cooler on the top rack. On the bottom rack of the open style metal cart, the ice scoop for the cooler was observed stored/located approximately three inches from the hallway floor in an open plastic container with the handled ice scoop completely enclosed in a partially open plastic bag. Additionally, a container of disposable plastic drinking cups was observed on the bottom rack of the cart situated approximately three inches from the hallway floor. At this time, Medical Record Coordinator (MRC) #13 observed the surveyor conducting the observation and the surveyor shared their concerns with them. MRC #13 observed, acknowledged, and confirmed understanding of the surveyor's concern. On 10/30/25 at 12:42PM the surveyor shared concerns with the facility's Director of Nursing who acknowledged and confirmed understanding of the surveyor's concerns.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview it was determined the facility failed to ensure staff performed hand hygiene. This was evident during 2 out of 2 random observations made by the surveyor during review of complaint #292569. The findings include: 1.) On 10/30/25 at 9:32AM the surveyor reviewed complaint #292569 which included an allegation that a facility staff member did not perform hand hygiene prior to medication administration and they had to direct the staff member to perform hand hygiene. On 10/30/25 at 10:00AM the surveyor conducted an interview with an anonymous source who reported to the surveyor that they observed a facility staff member administer medication with their bare hands and interact with other residents before entering their family member's room at which time they directed them to perform hand hygiene prior to working with their central line (intravenous catheter). On 10/30/25 at 10:42AM the surveyor performed a random observation of medication administration. The surveyor observed Licensed Practical Nurse (LPN) #11 proceeding down a hallway holding medication in a cup. LPN #11 then proceeded down a different hallway and entered the room of Resident #31, no hand hygiene was performed. LPN #11 administered medication to Resident #31 and was observed by the surveyor assisting the resident to get their pills into their mouth, and then placed a straw in the resident's mouth so they could drink water to swallow the pills. LPN #11 then walked out of the resident room holding the used empty cup with a straw in it in their hand. No hand hygiene was performed upon exit from the resident's room. At this time, the surveyor shared the concern with LPN #11 who acknowledged the concern and stated, Okay, thank you. After surveyor intervention, LPN #11 threw the cup away into the trash and performed hand hygiene. On 10/30/25 at 12:42PM the surveyor shared concerns with the facility's Director of Nursing who acknowledged and confirmed understanding of the surveyor's concerns. 2.) On 10/30/25 at 10:53AM the surveyor observed Geriatric Nursing Assistant (GNA) #12 enter Resident #32's room and bring ice water into the room with them. GNA #12 was observed moving the overbed table with their hands. GNA #12 removed the straw's wrapper for the resident's ice water and exited the room. No hand hygiene was observed to be performed by GNA #12. At this time, the surveyor shared their concern with GNA #12 who stated: Okay. On 10/30/25 at 12:42PM the surveyor shared concerns with the facility's Director of Nursing who acknowledged and confirmed understanding of the surveyor's concerns.</p>		