| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215020 | A. Building<br>B. Wing | 01/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Forestville Healthcare Center | 7420 Marlboro Pike<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on review of pertinent documents and interview with facility staff, it was determined that the facility failed to timely report to the State Survey Agency, the Office of Health Care Quality (OHCQ), an allegation of suspected resident abuse, and an allegation of misappropriation. This was evident for 2 (Resident # 164 and #163) of 2 residents reviewed for abuse during the recertification/complaint survey.The findings include:The 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, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are to be reported to the OHCQ in a timely manner.1) On 01/07/26 at approximately 1:35 PM, a review of the facility concern forms for the month of October 2025 revealed a concern form dated 10/30/2025 filed by Resident #164 of a concern that an assigned geriatric nursing assistant was roughly handling Resident #164. The facility's resolution was that the assigned Geriatric Nursing Assistant was removed from the assignment, and the Director of Nursing was made aware. However, the facility failed to report this allegation of abuse/neglect to the Office of Health Care Quality.<br><br>2) On 01/07/26, at approximately 1:45 PM, a review of October 2025 facility concern forms revealed an allegation dated 10/15/25 from Resident #163's complainant regarding a missing wallet/purse and wigs. The facility's resolution was searching the room, and Staff #21 (Unit Manager RN) requested a receipt from the complainant. However, the facility failed to report this alleged misappropriation to the Office of Health Care Quality.<br><br>On 01/07/26 at 2:49 PM, during an interview with the administrator, he identified himself as the Grievance Officer responsible for handling concerns. He outlined the following grievance process: A resident, family member, or staff member completes a form detailing the concern, which is then submitted to him. He subsequently distributes the form to the relevant department for follow-up and resolution. The complainant should then be notified of the resolution. However, the Administrator acknowledged that while allegations of abuse, neglect, or misappropriation should be reported to the Office of Health Care Quality (OHCQ), the specific allegations concerning Residents #163 and #164 were not reported.<br><br>On 01/08/26 at 11:06 AM, during an interview, the Director of Nursing (DON) confirmed that both the rough handling of a resident (constituting physical abuse) and a missing purse or wallet (constituting misappropriation) are mandatory reportable events to the Office of Health Care Quality and were not reported. The concern was communicated at the time of the interview. |

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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| 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 01/12/2026 |
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| NAME OF PROVIDER OR SUPPLIER Forestville Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 7420 Marlboro Pike Forestville, MD 20747 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of complaints, medical records, and staff interviews, the facility failed to ensure a resident received necessary treatment and services to promote their highest practicable well-being: evidence by failing to 1) follow Physician orders for Gastrointestinal interventions related to appointments, and 2) arrange a critical diagnostic test and a specialty consultation as ordered by the provider. This was evident for 2 (Resident #19 and #145) of 8 residents that were reviewed during this recertification/complaint survey.The findings included:According to [NAME] Medicine, a gastrostomy tube (G-tube) is a medical procedure in which a tube is inserted through the abdominal wall and into the stomach to provide an alternative route for delivering nutrition, fluids, and medications directly into the stomach, bypassing the mouth and esophagus. A modified barium swallow study (MBSS) is a real-time X-ray (fluoroscopic) procedure that evaluates how a patient swallows different liquids and foods to determine the cause of swallowing difficulties (dysphagia) or aspiration (food/liquid entering the lungs).<br><br>1) On 01/06/26 at 1:59 PM, a review of Resident #19's medical record revealed a physician order dated 11/12/25 to please schedule a gastrointestinal (GI) appointment for evaluation for gastrostomy tube (G-tube) removal.<br><br>On 01/07/26 at 9:25 AM, further review of Resident #19's medical record indicated a physician order dated 08/13/25 for a modified barium swallow study (MBSS).<br><br>On 01/07/26 at 9:56 AM, during an interview, the Director of Nursing (DON) explained the process for appointments: a nurse would receive the order from the physician and give it to the Unit Secretary to be scheduled.<br><br>On 01/07/26 at 12:22 PM, during an interview with Staff #21 (Unit Manager Licensed Practical Nurse LPN), described the appointment process: The unit secretary schedules the appointment after receiving the request from the nurse. The nurse is then informed of the scheduled appointment, notifies the resident/family, updates the order to include the Physician, date and time, and the Unit Secretary would schedule transportation.<br><br>On 01/08/26 at 8:44 AM, during an interview with Staff #28 (Unit Secretary), the appointment scheduling process was described. A nurse provides the necessary appointment or consultation information on a form, which the secretary then uses to schedule the appointment. Following scheduling, the secretary returns the appointment details to the nurse for the ordered appointment update. Staff #28 explicitly stated that she never received a request for Resident #19's MBS or GI consult and was not aware these appointments needed to be scheduled. She further explained she only became aware of these required appointments on 01/07/26 and began making calls to schedule.<br><br>On 01/09/26 at approximately 3:30 PM the Director of Nursing and Administrator were made aware of the concern.<br><br>2) A portion of investigating complaint 2689147 on 1/05/26 at 10:30 AM, the surveyor conducted a phone interview with complainant. The complainant claimed that the ENT (ear, nose, throat) appointment was scheduled more than 2 months after the hospital recommended for follow up which was delayed Resident #145's diagnosis, and active treatment had not been provided by the facility while he/she was in waiting.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Forestville Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 7420 Marlboro Pike Forestville, MD 20747 | |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/07/26 at 8:29 AM, the surveyor reviewed Resident #145's medical record. It was revealed that the resident's provider assessed him/her on 10/30/25 and ordered neck ultrasound: the test was performed at the facility on 10/30/25 with result of left neck solid mass measuring 3x2x2 cm. Recommendation for CT neck and chest. The CT neck order was placed on 10/30/25 at 11:11 PM, however it was not scheduled till the resident transferred to the hospital on [DATE].<br><br>Further review of Resident #145's medical record revealed that the resident was transferred to the hospital on [DATE] at 6:30 AM per the family's request to manage neck pain.<br><br>During the hospital stay from 11/10/25 to 11/11/25, Resident #145 received a CT scan of the neck. The results indicated enlarged, partially necrotic, and enhancing left-sided level 2 and 3 lymph nodes measuring 3.4 x 2.4 x 3.7 cm, suspicious for metastatic lymphadenopathy. An ENT evaluation and possible biopsy were recommended. Additionally, the hospital discharge summary noted: You must call each provider to make/verify your appointment with [ENT doctor's name] within one week.<br><br>The facility's provider wrote order for an ENT appointment and possible biopsy on 11/12/25; however, the appointment scheduled for 1/22/26. In an interview with Staff #28 (appointment scheduler) on 1/08/26 at 8:07 AM, the staff stated that 1/22/26 (more than 70 days later than the order placed) was the earliest possible date. When asked how she managed consultations requiring a specific time window, she stated she would inform the doctor's office, allowing the offices to communicate and adjust the schedule. Staff #28 verified she communicated the details of this case to the Unit Manager.<br><br>On 1/08/26 at 8:48 AM, Staff #43 (Unit Manager) stated, I updated Resident #145's family member regarding the earliest ENT appointment, and the family member stated they would search for an earlier appointment themselves. Since they said that, I took no additional action to adjust the schedule. However, a progress note written by Staff #43 on 11/14/25 stated: [Resident's family member] was updated about the upcoming ENT appointment on 1/22/26, which is the earliest we can get at this time.<br><br>In a phone interview on 1/12/26 at 8:53 AM, the family member stated, The nurse called me and said if I was able to look into it myself, I could seek an earlier appointment. The family member insisted they never indicated they would handle the scheduling entirely on their own.<br><br>A further review of the medical record on 1/08/26 revealed the resident was transferred back to the hospital on [DATE] for neck pain management. During that visit, a biopsy was conducted, resulting in a diagnosis of oropharyngeal cancer. On 1/12/26 at 10:00 AM, the Director of Nursing (DON) validated concerns that the diagnostic CT scan and ENT consultation were not arranged in a timely manner. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to maintain medical records that were complete and accurately documented for residents. This was evident for 2 (Resident #8 and #55) out of 52 residents reviewed during the facility's recertification/complaint survey.The findings include:The Health Care Decisions Act, which became effective 10/1/1993, applies in all healthcare settings. In Maryland a patient is presumed to have capacity until 2 physicians, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision. The certification shall be based on a personal examination of the patient after which the physician attests that a patient lacks the mental ability to understand or make informed decisions about their healthcare or personal affairs, often triggering legal processes like guardianship or activating advance directives for treatment, ensuring someone else can legally act on their behalf. 1) On 1/6/25 at 9:44 AM review of Resident #8's medical record revealed he/she was admitted to the facility on [DATE]. Further review revealed 2 Physician's Certifications Related to Medical Condition, Decision Making, and Treatment Limitations forms. The forms were signed and dated; however, the section titled, Certification Regarding Decision Making Capacity first question, where the provider checks if the resident either has adequate decision making capacity (including decisions about life-sustaining treatments) or lacks adequate decision making capacity (including decisions about life-sustaining treatments) for both forms was blank. The provider had not checked a box to certify whether or not the resident had or lacked adequate decision making capacity on either of the two forms. On 1/7/26 at 9:21 AM in an interview with Regional Director Clinical Services (RDCS #22) in a dual observation of the 2 physician certification forms, when asked if Resident #8 had or lacked capacity as neither box was checked, she did not respond. During the interview when asked if the forms were completed, she stated no. When asked if it was the expectation of the facility that the physician checks one of the boxes to indicate a resident had or lacked adequate decision making capacity, she stated yes. When asked what the date was on the form completed by the Medical Director she stated, 11/6/25 or 11/5/25. The surveyor stated the date was illegible and not easy to decipher and she acknowledged understanding. The surveyor shared these were concerns and the RDCS #22 confirmed understanding of the concerns. 2) On 1/10/26 at 5:00 PM review of facility reported incident #2695485 revealed on the initial report form submitted to the Office of Healthcare Quality, GNA (Geriatric Nursing Assistant) called the assigned nurse to resident room and reported laceration to resident's right pinky finger with bright red blood and swelling. On 1/11/26 at 1:49 PM review of Resident #55's progress notes revealed a note from Physician Assistant (PA #41) dated 12/16/25 8:05 PM CST (Central Standard Time) from a 20 minute video visit, [AGE] year old male/female presenting with laceration to left leg with bone exposure. The mechanism of injury is unknown as the nursing staff were unaware of how the injury was sustained. The patient is experiencing pain, and the wound is actively bleeding. The patient has a history of vascular dementia and serves as a poor historian due to cognitive impairment. The left fifth digit specifically shows active bleeding with bone exposure at the base. On 1/12/26 at 8:52 AM review of Pain Observation Tool dated 12/16/25 revealed RN #43 documented No for question number 1: Does the resident verbalize and/or exhibit non-verbal symptoms of pain. On 1/12/26 at 8:56 AM in an interview with Licensed Practical Nurse (LPN #24) when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, I look at their facial expressions expression such as are they<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | grimacing? During the interview when asked if there was a scale that the facility used for non-verbal residents, she stated, Yes, let me see. The name just went out of my memory. I can't think of it right now, but there is one we use where it rates their facial grimacing. On 1/12/26 at 9:00 AM in an interview with LPN #14 when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, Facial expression, the way they look, some will nod their head, some will not even eat, some will hold the part that is hurting such as their belly. During the interview when asked if there was a scale that the facility used for non-verbal residents, she stated they used the faces scale where they point to a face that represents a pain rating from 1-10. On 1/12/26 at 9:03 AM in an interview with Wound Nurse (WN #6) when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, I use the facial scale and they nod. I will also say, are you in pain? If yes, wink your eyes. And some can wink their eyes to tell me they are in pain.On 1/12/26 at 9:24 AM in an interview with the Director of Nursing (DON) when asked how non-verbal residents or residents who for whatever reason were unable to verbally express their pain level were assessed for pain, she stated there was a scale. Furthermore, she stated that once a nurse documented that a resident was showing signs of pain, a nonverbal pain scale would pop up. She searched through several examples and was unable to find one with a nonverbal pain scale to share with the surveyor. During the interview the survey requested a dual observation of Resident #55's 12/16/25 Pain Observation Tool. The surveyor also shared PA #41's note documenting the resident was in pain and asked the Director of Nursing to read question #1. The DON read it aloud and when asked if RN #43 had documented accurately for question 1, she stated no. The question does not simply ask does the resident verbalize pain, it also asks if the resident exhibits non-verbal symptoms of pain, so for nonverbal residents who are exhibiting signs of pain, when asked what would be considered accurate documentation, she stated to have answered the question as Yes. Additionally, in Section G, Pain Relief of the Pain Observation Tool, RN #43 documented Yes for Does the resident receive scheduled pain medication? and No for Does the resident receive a PRN (as needed) medication?. In a dual observation of Resident #55's December 2025 MAR revealed the resident was not ordered a scheduled pain medication and furthermore, that he/she was ordered a PRN pain medication, Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain/ fever Do not exceed 3gm of Tylenol in 24 hours. -Start Date-07/11/2022. During the interview the DON verified and confirmed RN #43's documentation was not accurate as Resident #55 was not ordered a scheduled pain medication and was ordered a PRN pain medication. The surveyor pointed out that PA #41's note documented a left leg laceration as well as a laceration to the left pinky finger. The DON stated that was not accurate documentation and the resident only had a laceration to his/her right pinky finger. A dual observation of Resident #55's hospital Discharge summary dated [DATE] verified that Resident #55 was seen for a laceration to the right pinky. The surveyor shared these were concerns and the DON acknowledged understanding of the medical records concerns. |