STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215020	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forestville Rehabilitation and Wellness Center	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on record review and staff interview, the facility failed to protect a resident's dignity (resident #6) by failing to assist the resident with requested adl tasks resulting in the resident leaving his/her room with his/her lower body being partially unclothed. This was evident in 1 of 14 residents reviewed during the facility's complaint survey. The findings include:Interview with Resident #6 on 5/29/26 at 8:40am revealed Resident #6 stated he/she left his/her room on 5/7/26 at breakfast time (approximately 7:30am) upset that he/she did not receive the ADL (Activities of Daily Living) assistance requested earlier in the morning. LPN #10 told Resident #6 that his/her robe wasn't covering his/her backside. Resident #6 then had a heated conversation with LPN #10 which resulted in LPN #10 loudly saying obscenities to Resident #6. Resident #6 then stated that the Social Services Director #8 intervened in the argument between Resident #6 and LPN #10 and attempted to calm both Resident #6 and LPN #10 by standing between them. Unit Manager #7 took LPN #10 into his/her office. Social Services Director # 8 took Resident #6 into his/her office and asked Resident #6 if he/she felt safe in the facility. Resident #6 stated that he/she felt safe and then complained that nursing staff failed to assist with ADL care. Resident #6 also stated that he/she felt that if nursing staff had assisted with the requested ADL care, the resident wouldn't have come out of his/her room with his/her backside exposed. Record review of Resident #6's medical records on 6/2/26 at 9:00am revealed the resident had a diagnosis of hemiparesis/hemiplegia which is the paralysis of one side of the body. The resident's diagnosis required the resident to need assistance with ADL care. Interview with LPN #10 on 6/2/26 at 9:50 am confirmed LPN #10 observed Resident #6 leave his/her room partially covered with a robe. LPN #10 then stated that Resident #6 was screaming obscenities about nursing staff when nursing staff attempted unsuccessfully to calm Resident #6. LPN #10 then stated that he/she attempted to calm Resident #6 and cautioned other nursing staff not to interact with the resident. Resident #6 directed his/her obscenities toward LPN #10. LPN #10 denies screaming at Resident #6 or saying any obscenities to Resident #6. Unit Manager #7 calmed Resident #6 and took LPN #10 away from the resident into his/her office. The surveyor asked LPN #10 if any of the nursing staff attempted to assist Resident #6 with covering his/her body. LPN #10 did not remember. During an interview with the Assistant Director of Nursing (ADON) on 6/2/26 at 1:30pm, the surveyor asked the ADON of the facility policy on how nursing staff would protect a resident's dignity. The ADON stated that nursing staff would protect a resident's dignity by respecting the resident's right to have personal preference in their daily lives. The surveyor informed the ADON that Resident #6 felt that his/her dignity was violated on 5/7/26 when nursing staff failed to assist the resident with requested ADL tasks and per Resident #6 felt nursing staff failure to assist with requested ADL tasks led to the altercation with LPN #10 on the morning of 5/7/26.

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on record review and staff interview, the facility failed to provide residents, who gave permission to allow the facility to manage their SSI/SSA funds, access to surplus SSI/SSA fund on demand for the month of April 2026. This was evident for 3 of 14 residents (Resident #3, #11, & #13) reviewed during a complaint survey. The findings include: Surveyor review of a complaint 2981750 on 5/29/26 at 9:40am that was sent to OHCQ on 4/13/26 and updated on 5/5/26 alleged the facility failed to provide resident surplus SSI/SSA funds when requested. Interview with Resident #3 on 5/29/26 at 10:40am reveal Resident #3 alleged that he/she was denied his/her surplus SSI/SSA funds when requested for the month of April 2026. Resident #3 stated that he/she was aware of the change in ownership as of February 2026. The facility did not make the resident aware that he/she wouldn't be able to access surplus SSI/SSA funds for the month of April 2026. Additionally, 2 residents' (Resident #11 and #13) complaints that the facility failed to provide access to surplus SSI/SSA funds for the month of April 2026 were also reviewed. Interview with the Administrator on 6/1/26 at 3:30pm regarding the residents' complaints of the facility's failure to provide access to surplus SSI/SSA funds for the month of April 2026 revealed that the Administrator was unaware of any financial issues with resident's accounts and resident funds are managed through the Business Office Manager. Interview with the Business Office Manager #17 on 6/2/26 at 7:40am confirmed that the facility's Business Office are responsible for all resident's funds and distribute resident surplus SSI/SSA funds for residents that gave permission to have the facility manage their SSI/SSA funds. Business Office Manager #17 also confirmed that he/she has been employed with the facility for 8 years and he/she is still employed as the Business Office Manager when the facility changed owners on 4/1/26. The surveyor asked Business Office Manager #17 if the facility had a issue with providing resident's access to their surplus SSI/SSA funds in April 2026. Business Office Manager #17 confirmed the facility was unable to distribute access SSI/SSA to residents because the former owner didn't send the facility resident's SSI/SSA funds until 4/17/26. Any surplus of resident funds was not available to the resident until 5/1/26. The Surveyor asked Business Office Manager #17 about the availability of residents receiving checks for the balance of their surplus funds. Business Office Manager #17 admitted the facility under the new owners could not issue checks until 6/1/26. Business Office Manager #17 provided the survey team with the financial statements for Residents #3, #11, and #13. The financial statements confirmed resident's SSI/SSA funds were not available for facility use until 4/17/26. The financial statements also confirm that the first disburse of surplus SSI/SSA funds was not until 5/1/26.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on investigation into a complaint, observation, and staff interview, the facility failed to maintain a homelike environment for residents. This was evident for 1 of 1 resident bathrooms reviewed during the complaint investigation.The findings include: On 06/02/26, a review of Complaint #3001489 revealed allegations related to facility maintenance and environmental conditions.On 06/04/26 at 12:38 PM, during a random tour of the facility, observation of the shared bathroom serving residents in room [ROOM NUMBER] revealed the following environmental concerns: One of three light fixtures above the sink was missing a cover; The wall surrounding the grab bar and toilet tissue dispenser contained unfinished wall repairs with visible patching material; Unfinished wall repairs with visible patching material and gaps were also observed beneath the sink, along with gaps at the base of the wall; and The ceiling contained one displaced ceiling tile and three ceiling tiles with brown water stains. On 06/04/26 at 1:45 PM, during an interview, the Maintenance Director confirmed the environmental concerns observed in the bathroom serving residents in room [ROOM NUMBER], including the missing light fixture cover, unfinished wall repairs, stained ceiling tiles, and displaced ceiling tile. The Maintenance Director stated he would come up with a plan to address the concerns.At the time of exit conference, no additional information was provided by the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and staff interview; it was determined that the facility failed to protect a resident (resident #6) from verbal abuse by a facility staff member. This was evident for 1 of 14 residents reviewed during a complaint survey. The findings include:Record review on 5/28/26 at 9:30am revealed an incident report sent by the facility 3006910 to the State of Maryland's Office of Health Care Quality on 5/7/26. In this incident report, the facility alleged LPN # 10 verbally abused Resident #6. On 5/13/26, the facility completed its investigation of the alleged verbal abuse incident and determined LPN #10 did not verbal abuse Resident #6. Interview with Resident #6 on 5/29/26 at 8:40am confirmed LPN #10's verbal abuse of Resident #6 on 5/7/26. Resident #6 stated he/she left his/her room on 5/7/26 at breakfast time (approximately 7:30am) upset that he/she did not receive the ADL (Activities of Daily Living) assistance requested earlier in the morning. LPN #10 told Resident #6 that his/her robe wasn't covering his/her backside. Resident #6 then had a heated conversation with LPN #10 which resulted in LPN #10 loudly saying obscenities to Resident #6. Resident #6 then stated that Social Services Director #8 intervened in the argument between Resident #6 and LPN #10 and attempted to calm both Resident #6 and LPN #10 by standing between them. Unit Manager #7 took LPN #10 into his/her office. Social Services Director # 8 took Resident #6 into his/her office and asked Resident #6 if he/she felt safe in the facility. Resident #6 stated that he/she felt safe and then complained that nursing staff failed to assist with his/her ADL care. Resident #6 also stated that he/she felt that if nursing staff had assisted with the requested ADL care, the resident wouldn't have come out of his/her room with his/her backside exposed. Record review of the facility investigation on 6/2/26 at 7:30am confirmed the alleged verbal abuse incident took place on 5/7/26. The facility's investigation summarized the alleged verbal abuse incident as follows: [Resident #6] came out of his/her room on 5/7/26 partially covered with a robe. Nursing staff attempted to re-direct the resident. The resident responded with obscenities. LPN#10 attempted to calm down the resident at first but Social Service Director #8 observed LPN #10 screaming at the resident. Unit Manager #7 calmed Resident #6 and LPN #10 down from the verbal altercation. The facility's investigation contained written statements from LPN #10, Social Service Director #8, Unit Manager #7 and Resident #6, as well as other written statements from other nursing staff present during the alleged verbal abuse incident. Interview with the Assistant Director of Nursing (ADON) on 6/2/26 at 9:00am revealed LPN #10 was suspended without pay from 5/7/26 to 5/17/26. The ADON provided the surveyor with payroll records to confirm the dates of suspension. Interview with LPN #10 on 6/2/26 at 9:50 am confirmed LPN #10 was scheduled to work from 7am to 3:00pm on the 2nd floor of the facility on 5/7/26. LPN #10 also confirmed he/she had a verbal altercation with Resident #6 on 5/7/26 at approximately 7:30am. LPN #10 stated that he/she observed Resident #6 leaving his/her room partially covered with a robe. LPN #10 then stated that Resident #6 was screaming obscenities about nursing staff when nursing staff attempted unsuccessfully to calm resident. LPN #10 then stated that he/she attempted to calm Resident #6 and cautioned other nursing staff not to interact with the resident. Resident #6 then directed his/her obscenities toward LPN #10. LPN #10 denies screaming at Resident #6 or saying any obscenities to Resident #6. Unit Manager #7 calmed Resident #6 and took LPN #10 away from the resident into his/her office. Unit Manager #7 suspended LPN #10 pending investigation of verbal abuse. Interview with Social Services Director #8 on 6/2/26 at 10:30am revealed Social Services Director #8 observed the alleged verbal abuse incident on 5/7/26. Social Services Director #8 stated that his/her office is located on the 2nd floor by the nurses' station. Social Services Director #8 stated that he/she heard a verbal altercation on 5/7/26 at approximately 7:30am. Social Services Director #8 left his/her office and observed Resident #6 and LPN #10 standing close to each other with their fingers pointed into each other's face. Social Services Director #8 also heard Resident #6 and LPN #10 screaming obscenities at each other. Social (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services Director #8 attempted to remove LPN #10 from the altercation but he/she refused to move. Eventually, Unit Manager #7 calmed Resident #6 and LPN #10. Unit Manager #7 took LPN #10 into his/her office and Social Services Director #8 took Resident #6 into his/her office to ensure the resident felt safe in the facility. The resident stated that he/she felt safe and explained nursing staff failed to assist the resident with ADK care when requested. Social Services Director #8 escorted Resident #6 back to his/her room. Social Services Director #8 then stated that he/she reported the altercation between LPN #10 and Resident #6 at approximately 9:30am to the Regional Director of Clinical Operations # 18 in morning meeting. Regional Director of Clinical Operations #18 made Social Services Director #8 aware of the time constraints involved with reporting alleged abuse to OHCQ and later gave Social Services Director #8 a refresher training on abuse reporting. Interview with Unit Manager #7 on 6/2/26 at 12:02pm confirmed the alleged verbal abuse incident occurred 5/7/26 at approximately 7:30am. Unit Manager #7 stated that he/she heard LPN #10 yelling obscenities to Resident #6 after Resident #6 insulted LPN #10. Unit Manager #7 calmed LPN #10 and Resident #6. LPN #10 stated that he/she wanted to turn in the unit keys and go home. Unit Manager #7 took LPN #10 into his/her office to calm the nurse. After LPN #10 was calmed, Unit Manager #7 called the Director of Nursing (DON) to report the altercation. The DON stated LPN #10 would need to be suspended pending facility investigation of the alleged verbal abuse incident. Interview with the Administrator and Regional Director of Clinical Operations #18 on 6/3/26 at 10:30am confirm that Social Services Director #8 reported the verbal abuse allegation on 5/7/26 in the 9:30am morning meeting. Regional Director of Clinical Operations #18 stated that he/she immediately started the facility investigation at the time Social Services Director #8 reported the incident in morning meeting. The Administrator stated that he/she was informed of the alleged verbal abuse incident at approximately 10:00am on 5/7/26 by the DON. The surveyor informed the Administrator and Regional Director of Clinical Operations #18 Unit Manager #7 stated she called the DON after the alleged verbal abuse incident on 5/7/26 at approximately 8:00am. The Administrator clarified his/her former statement regarding the DON. The Administrator stated the DON informed him/her of the conversation he/she had with Unit Manager #7 earlier in the day about LPN#10's request to leave for the day. Unit Manager #7 failed to inform the DON of the alleged verbal abuse incident. The DON became aware of the alleged verbal abuse incident when Social Services Director #8 reported the alleged verbal abuse incident in morning meeting on 5/7/26 at 9:30am.

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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. Based on record review and staff interview, the facility failed to timely report an alleged verbal abuse of a resident (resident #6) by facility nursing staff to OHCQ. This was evident with 1 of 14 resident records reviewed during a complaint survey. The findings include: Record review on 5/28/26 at 9:30am revealed an incident report sent by the facility 3006910 to the State of Maryland's Office of Health Care Quality on 5/7/26. In this incident report, the facility alleged LPN # 10 verbally abused Resident #6. On 5/13/26, the facility completed its investigation of the alleged verbal abuse incident and determined LPN #10 did not verbal abuse Resident #6. Interview with Resident #6 on 5/29/26 at 8:40am confirmed the alleged verbal abuse incident occurred on 5/7/26 at approximately 7:30am. Record review of the facility investigation on 6/2/26 at 7:30am confirmed the alleged verbal abuse incident took place on 5/7/26. The facility's initial investigation report sent to OHCQ revealed that the alleged verbal abuse incident occurred at breakfast on 5/7/26 and staff informed the facility administration of the alleged verbal abuse incident at 9:55am. The facility reported the alleged verbal abuse incident at 10:28 am on 5/7/26. Interview with LPN #10 on 6/2/26 at 9:50 am confirmed he/she had a verbal altercation with Resident #6 on 5/7/26 at approximately 7:30am. Interview with Social Services Director #8 on 6/2/26 at 10:30am revealed that Social Services Director #8 observed the alleged verbal abuse incident on 5/7/26. Social Services Director #8 stated that he/she heard a verbal altercation on 5/7/26 at approximately 7:30am. Social Services Director #8 then stated that he/she reported the altercation between LPN #10 and Resident #6 at approximately 9:30am to the Regional Director of Clinical Operations # 18 in morning meeting. Regional Director of Clinical Operations #18 made Social Services Director #8 aware of the time constraints involved with reporting alleged abuse to OHCQ and later given a refresher training on abuse reporting. Interview with Unit Manager #7 on 6/2/26 at 12:02pm confirmed the alleged verbal abuse incident occurred 5/7/26 at approximately 7:30am. Unit Manager #7 calmed LPN #10 and resident #6. After LPN #10 was calmed, Unit Manager #7 called the Director of Nursing (DON) to report the altercation. Interview with the Administrator and Regional Director of Clinical Operations #18 on 6/3/26 at 10:30am confirm that Social Services Director #8 reported the verbal abuse allegation on 5/7/26 in the 9:30am morning meeting. Regional Director of Clinical Operations #18 stated that he/she immediately started the facility investigation at the time Social Services Director #8 reported the incident in morning meeting. The Administrator stated that he/she was informed of the alleged verbal abuse incident at approximately 10:00am on 5/7/26 by the DON. The surveyor informed the Administrator and Regional Director of Clinical Operations #18 Unit Manager #7 stated she called the DON after the alleged verbal abuse incident on 5/7/26 at approximately 8:00am. The Administrator clarified his/her former statement regarding DON. The Administrator stated the DON stated informed him/her of the conversation he/she had with Unit Manager #7 earlier in the day about LPN#10's request to leave for the day. Unit Manager #7 failed to inform the DON of the alleged verbal abuse incident. The DON became aware of the alleged verbal abuse incident when Social Services Director #8 reported the alleged verbal abuse incident in morning meeting on 5/7/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 investigation into a complaint, closed record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to address residents' individualized care needs. This was evident for 1 (Resident #2) of 5 residents reviewed for care plans during the complaint survey. The findings include: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.On 06/02/26, a review of Complaint #3001489 revealed allegations related to the care provided to Resident #2.On 06/03/26 at 9:37 AM, a review of Resident #2's closed record revealed that the resident was admitted to the facility on [DATE] with diagnoses that included Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris and Heart Failure, Unspecified.Review of Resident #2's emergency room (ER) Discharge summary dated [DATE] revealed the resident had chronic systolic heart failure with an ejection fraction of 30% to 35%.Review of Resident #2's comprehensive care plan failed to reveal goals or interventions developed to address the resident's cardiac diagnoses, including Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris and chronic systolic heart failure.On 06/04/26 at 1:37 PM, during an interview, the Assistant Director of Nursing (ADON) reviewed Resident #2's comprehensive care plan and confirmed there was no care plan developed to address the resident's cardiac needs. The ADON stated that residents' care plans are expected to address their individualized care needs.At the time of exit conference, no additional information was provided by the facility.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on investigation of a complaint, record review and interviews, it was determined that the facility failed to ensure physician documentation accurately reflected the resident's dietary plan of care. This was evident for 1 (Resident #2) of 10 residents reviewed during the complaint survey.The findings include: On 06/02/26, a review of Complaint #3001489 related to care concerns involving Resident #2 was conducted.On 06/03/26 at 9:37 AM, review of Resident #2's clinical record revealed the resident was admitted to the facility on [DATE] for continued care and rehabilitation following hospitalization.Review of Resident #2's physician orders revealed an order for a regular diet, regular texture, and thin liquids with a start date of 03/04/26. The order was electronically signed by the Medical Director. Further review of Resident #2's clinical record revealed a physician assessment (History and Physical) dated 03/05/26 that included a plan of care to continue medications as ordered and a pureed diet with aspiration precautions. The assessment was electronically signed by the Medical Director.Review of Resident #2's nutritional assessment dated [DATE] revealed the assessment was completed by the Registered Dietitian (RD) based on a regular diet, regular texture, and thin liquids.On 06/04/26 at 11:09 AM, during an interview, the RD stated that she based her nutritional assessment on the dietary orders entered in Resident #2's electronic clinical record.On 06/04/26 at 11:25 AM, during an interview, the Medical Director reviewed Resident #2's clinical record and confirmed that he electronically signed the physician orders dated 03/04/26 for a regular diet, regular texture, and thin liquids and the physician assessment dated [DATE] documenting a pureed diet with aspiration precautions. The Medical Director stated the resident was on a regular diet and that the pureed diet with aspiration precautions documented in the physician assessment was entered in error.