STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Haven Nursing and Rehabilitation Ctr	701 Edmondson Avenue Catonsville, MD 21228

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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on review of medical records, facility documentation, complaint MD00205968 and staff interviews, it was determined the facility failed to ensure all residents were free from abuse. This was evident for 3 (Resident #2, #3, and #4) of 4 residents reviewed for abuse during a complaint survey. The findings include: Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse, is defined at S483.5 as non-consensual sexual contact of any type with a resident. Misappropriation of resident property, as defined at S483.5, means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. A review of Resident #1's closed medical on 05/28/24 revealed Resident #1 was admitted into the facility with diagnoses that included but not limited to dementia, mood disturbance, psychotic disturbance, and bipolar disease. On 01/09/24, Resident #1's attending physician certified that Resident #1 was unable to make any medical, treatment, and financial decisions due to dementia. Review of Resident #1 medical record revealed a behavior care plan, initiated on 01/17/24, that identified a problem: Resident #1 has a behavior problem (refusing care, sad mood, tearfulness, hoarding, setting fires, wandering into other residents rooms, sexually inappropriate, disrobing in front of others, false accusations, verbal and physical aggression, exit seeking, packing belongings, yelling at others, playing in feces, smearing feces, placing briefs in toilet) r/t dementia with behaviors, insomnia, and depression (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
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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 0600 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident #1's closed medical record revealed a nursing progress note, dated 01/24/24 at 4:30 PM, where Staff member #16 was doing rounds and looking for Resident #4. Resident #4 was found in Resident #1's room, seated in a chair. Staff member #16 observed Resident #1 standing in front of Resident #4, stroking Resident #4's head with Resident #1's genitals exposed. Staff member #16 immediately informed the nurse of Resident #1's inappropriate sexual behavior and separated the two residents. Resident #1's physician was notified of Resident #1's inappropriate sexual behavior and instructed the nursing staff to obtain a psychiatric consult. On 01/25/24, Resident #1 was evaluated by nurse practitioner, Staff Member #17, for sexually inappropriate behavior. Staff member #17 documented the 01/24/24 incident and indicated speaking to Resident #1's family member. Resident #1 had been moved to a different floor on 01/24/24. In the interview, Resident #1's family member informed Staff member #17 that Resident #1 had a history of deviant sexual behavior including fondling a comatose patient in the past and exposing his private parts in public. Staff member #17's 01/24/24 treatment plan for Resident #1 was to: provide mindfulness training and family support, staff to approach patient respectfully and be clear about upcoming nursing care. In an interview with the facility director of nurses (DON) on 05/29/24 at 1:40 PM, the DON indicated the facility had not investigated nor notified the State agency of the allegation of sexual abuse on 01/24/24. Further review of Resident #1's closed medical records revealed a nursing progress note that documented on 03/27/24 at 7:20 AM, Resident #1 had taken Resident #3's personal letters and other items. Resident #3 was noted to be crying and very upset. Resident #3 suffers from quadriplegia, a stroke, anxiety, difficulty speaking, aphasia, and is totally dependent upon the nursing staff for all his/her care needs. The staff indicated that the facility administrator was made aware of the incident. At 10:45 AM on 03/27/24, Resident #1 was observed by a therapy staff member digging into Resident #3's Vaseline and then observed Resident #1 hit Resident #3 in the arm. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON stated that the facility had not investigated, obtained witness statements, nor notified the State agency of the allegation of abuse on 03/27/24. Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who was bed bound and demented on 05/08/24. Review of Resident #2's medical record on 05/28/24 revealed that Resident #2 was admitted to the facility on [DATE] with diagnoses that include but not limited to: Traumatic [NAME] Injury, depression, anxiety, and intellectual disabilities. Resident #2 was totally dependent upon the nursing staff for all their care needs. Further review revealed that on 05/08/24 at approximately 6:30 am, Resident #1 was observed inappropriately touching Resident #2 by Staff member #7. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview with Staff member #7 on 05/30/24 at 2:30 PM, Staff member #7 stated s/he recalled observing Resident #1 inappropriately touching Resident #2 in Resident #2's room on 05/08/24. Staff member #7 stated that s/he observed Resident #1 with his/her hand in Resident #2's diaper and it appeared that Resident #1 was digging in Resident #2's diaper with his/her hand. The staff documented that Resident #1's physician was notified, and the nursing staff implemented Q 15-minute observations. Resident #2 was unable to recall the incident when interviewed by the facility staff. On 05/18/24 at approximately 7:20 AM, Resident #1 was again observed in Resident #2's room. Resident #1 was observed by Staff member #5 inappropriately touching Resident #2 again. (hands in his/her diaper). In an interview with Staff member #5 on 05/30/24 at 2:39 PM, Staff member #5 stated that s/he observed Resident #1, in Resident #2's room on 05/18/24 at approximately 7:20 AM. Staff member #5 stated s/he observed Resident #1 with his/her hand in Resident #2's diaper and Resident #1 appeared to be rubbing Resident #2 in a circular motion. The facility staff initiated an investigation, placed Resident #1 on 1:1 supervision, and notified Resident #1's physician. Resident #1 was ultimately emergency petitioned to the hospital emergency roiagnom on [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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a closed medical record, and staff interview, it was determined that the facility failed to implement abuse prevention polices as evidenced by staff's failure to, 1) immediately notify the facility administrator of an allegation of resident abuse, sexual abuse, and misappropriation of resident property, 2) immediately initiate an investigation into the allegations of resident abuse, and 3) report the allegations of resident abuse to the State Regulatory Agency (Office of Health Care Quality). This was evident for 2 (Resident #1, #3) of 3 residents reviewed during a complaint survey. The findings include: Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse, is defined at S483.5 as non-consensual sexual contact of any type with a resident. Misappropriation of resident property, as defined at S483.5, means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 1) A review of Resident #1's closed medical on 05/28/24 revealed Resident #1 was admitted into the facility on [DATE] with diagnoses that included but not limited to dementia, mood disturbance, psychotic disturbance, and bipolar disease. On 01/09/24, Resident #1's attending physician attending physician certified that Resident #1 is unable to make any medical, treatment, and financial decisions due to dementia. Further review of Resident #1's closed medical record revealed a nursing progress note, dated 01/24/24 at 4:30 PM, where Staff member #16 was doing rounds and looking for Resident #4. Resident #4 was found in Resident #1's room, seated in a chair. Staff member #16 observed Resident #1 standing in front of Resident #4, stroking his/her head with his/her genitals exposed. Staff member #16 immediately informed the nurse of Resident #1's inappropriate sexual behavior and separated the two residents. Resident #1's physician was notified of Resident #1's inappropriate sexual behavior and instructed the nursing staff to obtain a psychiatric consult. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/25/24, Resident #1 was evaluated by nurse practitioner, Staff Member #17, for sexually inappropriate behavior. Staff member #17 documented the 01/24/24 incident and indicated speaking to Resident #1's family member. Resident #1 had been moved to a different floor on 01/24/24. In the interview, Resident #1's family member informed Staff member #17 that Resident #1 had a history of deviant sexual behavior including fondling a comatose patient in the past and exposing his private parts in public. Staff member #17's 01/24/24 treatment plan for Resident #1 was to: provide mindfulness training and family support, staff to approach patient respectfully and be clear about upcoming nursing care. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON indicated the facility had not investigated nor notified the State agency of an allegation of abuse on 01/24/24. 2) On 02/02/24 at 1:45 PM, the nursing staff documented Resident #1 was observed attempting to touch female residents' breasts in the hallways. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON stated that the facility had not investigated, obtained witness statements, nor notified the State agency of an allegation of abuse on 02/02/24. 3) Further review of Resident #1's closed medical records revealed a nursing progress note indicating that on 03/27/24 at 7:20 AM, Resident #1 had taken Resident #3's personal letters and other items. Resident #3 was noted to be crying and very upset. Resident #3 suffers from quadriplegia, a stroke, anxiety, difficulty speaking, aphasia, and a gastrostomy tube and is totally dependent upon the nursing staff for all his/her care needs. The staff indicated that the facility administrator was made aware of the incident. At 10:45 AM on 03/27/24, Resident #1 was observed by a therapy staff member digging into Resident #3's Vaseline and then observed Resident #1 hit Resident #3 in the arm. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON stated that the facility had not investigated, obtained witness statements, nor notified the State agency of an allegation of abuse on 03/27/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a closed medical record and staff interview, it was determined the facility failed to initiate an investigation into a reported allegation of abuse. This was evident for 2 (Resident #1, #3) of 3 residents reviewed during a complaint survey. The findings include: Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse, is defined at S483.5 as non-consensual sexual contact of any type with a resident. Misappropriation of resident property, as defined at S483.5, means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 1) A review of Resident #1's closed medical on 05/28/24 revealed Resident #1 was admitted into the facility on [DATE] with diagnoses that included but not limited to dementia, mood disturbance, psychotic disturbance, and bipolar disease. On 01/09/24, Resident #1's attending physician attending physician certified that Resident #1 is unable to make any medical, treatment, and financial decisions due to dementia. Further review of Resident #1's closed medical record revealed a nursing progress note, dated 01/24/24 at 4:30 PM, where Staff member #16 was doing rounds and looking for Resident #4. Resident #4 was found in Resident #1's room, seated in a chair. Staff member #16 observed Resident #1 standing in front of Resident #4, stroking his/her head with his/her genitals exposed. Staff member #16 immediately informed the nurse of Resident #1's inappropriate sexual behavior and separated the two residents. Resident #1's physician was notified of Resident #1's inappropriate sexual behavior and instructed the nursing staff to obtain a psychiatric consult. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON indicated the facility had not investigated nor notified the State agency of an allegation of abuse on 01/24/24. 2) On 02/02/24 at 1:45 PM, the nursing staff documented Resident #1 was observed attempting to touch female residents' breasts in the hallways. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON stated that the facility had not investigated, obtained witness statements, nor notified the State agency of an allegation of abuse on 02/02/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Further review of Resident #1's closed medical records revealed a nursing progress note indicating that on 03/27/24 at 7:20 AM, Resident #1 had taken Resident #3's personal letters and other items. Resident #3 was noted to be crying and very upset. Resident #3 suffers from quadriplegia, a stroke, anxiety, difficulty speaking, aphasia, and a gastrostomy tube and is totally dependent upon the nursing staff for all his/her care needs. The staff indicated that the facility administrator was made aware of the incident. At 10:45 AM on 03/27/24, Resident #1 was observed by a therapy staff member digging into Resident #3's Vaseline and then observed Resident #1 hit Resident #3 in the arm. In an interview with the facility director of nurses on 05/29/24 at 1:40 PM, the DON stated that the facility had not investigated, obtained witness statements, nor notified the State agency of an allegation of abuse on 03/27/24.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a complaint, a closed clinical record and staff interviews, it was determined that the facility failed to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. This was evident for 1 (Resident #1) of 3 residents reviewed during a complaint survey. The findings include: Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who is bed bound and demented. Resident #1 was evaluated in the emergency room and cleared for discharge back to the nursing facility on 05/19/24. The facility refused to have Resident #1 return from the hospital on 05/19/24. In an interview with the facility administrator and director of nurses (DON) on 05/28/24 at 10:30 am, the DON stated that the facility did not accept the resident back from the hospital for the safety of the female residents. The DON stated the facility was aware of Resident #1's sexual behaviors for over a year. During the conversation the facility administrator stated that Resident #1 was not issued a 30-day involuntary notice, no written correspondence was sent out to the resident's representative, nor the local State Ombudsman's office, nor sent with the resident to the hospital on 05/18/24. The administrator stated that there are no administrative staff in the facility during the weekend and 05/18/24 was a Saturday. In a telephone interview with Resident's #1 physician, staff member #10, on 05/30/24 at 9:57 am, Resident #1's physician stated that Resident #1's primary care physician has been away on vacation for 3 weeks and that S/he is the current covering physician for Resident #1 during the week only Monday thru Friday. The on-call team (nurse practitioners) take phone calls regarding resident care on the weekends. Staff member #10 stated that S/he had not received any notifications by staff on 05/18/24 regarding Resident #1. Staff member #10 stated that the facility staff had not contacted him/her about Resident #1 for any reason since S/he started covering for Resident #1's primary care physician on 05/13/24. In a telephone interview with the weekend on-call nurse practitioner, staff member #12, on 05/30/24 at 10:02 am, staff member #12 stated that S/he works for an on-call group that cover physician calls on the weekends. Staff member #12 stated that S/he was on call for the facility on Saturday 05/18/24. Staff member #12 stated that S/he was notified by telephone, once, about Resident #1's sexual behavior on 05/18/24 and instructed the nursing staff to monitor Resident #1. Staff member #12 stated that S/he did not specify how to monitor Resident #1 nor recalled having a discussion about sending Resident #1 out to the hospital by 911 ambulance. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with Resident #1's representative on 05/30/24 at 11:06 am, Resident #1's representative stated that S/he was never notified that the facility would not accept Resident #1 back to the facility after being sent to the hospital. Resident #1's representative also stated that S/he was not made aware the Resident #1 was no longer residing at the facility and that the facility would not take him/her back. In a telephone interview with the facility medical director on 05/30/24 at 12:02 PM, the facility medical director stated that S/he was not involved in discussions with staff about not allowing Resident #1 to return to the facility on [DATE]. The facility medical director stated that S/he was aware in a meeting that Resident #2, who the medical director is the primary care physician for, had been the victim of Resident #1 on 05/08/24 and 05/18/24.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a complaint, a closed clinical record and staff interviews, it was determined that the facility failed to initiate the process to notify the resident/resident representative in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (Resident #1) of 3 residents reviewed during a complaint survey. The findings include: Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who is bed bound and demented. Resident #1 was evaluated in the emergency room and cleared for discharge back to the nursing facility on 05/19/24. The facility refused to have Resident #1 return from the hospital on 05/19/24. In an interview with the facility administrator and director of nurses (DON) on 05/28/24 at 10:30 am, the DON stated that the facility did not accept the resident back from the hospital for the safety of the female residents. The DON stated the facility was aware of Resident #1's sexual behaviors for over a year. During the conversation the facility administrator stated that Resident #1 was not issued a 30-day involuntary notice, no written correspondence was sent out to the resident's representative, nor the local State Ombudsman's office, nor sent with the resident to the hospital on 05/18/24. The administrator stated that there are no administrative staff in the facility during the weekend and 05/18/24 was a Saturday. In a telephone interview with Resident's #1 physician, staff member #10, on 05/30/24 at 9:57 am, Resident #1's physician stated that Resident #1's primary care physician has been away on vacation for 3 weeks and that s/he is the current covering physician for Resident #1 during the week only Monday thru Friday. The on-call team (nurse practitioners) take phone calls regarding resident care on the weekends. Staff member #10 stated that s/he had not received any notifications by staff on 05/18/24 regarding Resident #1. Staff member #10 stated that the facility staff had not contacted him/her about Resident #1 for any reason since s/he started covering for Resident #1's primary care physician on 05/13/24. In a telephone interview with Resident #1's representative on 05/30/24 at 11:06 am, Resident #1's representative stated that S/he was never notified that the facility would not accept Resident #1 back to the facility after being sent to the hospital. Resident #1's representative also stated that S/he was not made aware the Resident #1 was no longer residing at the facility and that the facility would not take him/her back. In a telephone interview with the facility medical director on 05/30/24 at 12:02 pm, the facility medical director stated that s/he was not involved in discussions with staff about not allowing Resident #1 to return to the facility on [DATE]. The facility medical director stated that s/he was aware in a meeting that Resident #2, who the medical director is the primary care physician for, had been the victim of Resident #1 on 05/08/24 and 05/18/24.

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a complaint, a closed clinical record and staff interviews, it was determined that the facility failed to ensure safe and orderly transfer or discharge from the facility. This was evident for 1 (Resident #1) of 3 residents reviewed during a complaint survey. The findings include: Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who is bed bound and demented. Resident #1 was evaluated in the emergency room and cleared for discharge back to the nursing facility on 05/19/24. The facility refused to have Resident #1 return from the hospital on 05/19/24. A review of Resident 1's closed medical record on 05/28/24 revealed that Resident #1 was admitted to the facility on [DATE]. On 03/06/24, the facility social worker initiated a care plan the indicated Resident #1 is to remain at the facility for Long-Term care. Goals included helping Resident #1 adjust to the facility with no negative affects. Staff approaches included staff will assist with adjustment to facility. In an interview with the facility administrator and director of nurses (DON) on 05/28/24 at 10:30 am, the DON stated that the facility did not accept the resident back from the hospital for the safety of the female residents. The DON stated the facility was aware of Resident #1's sexual behaviors for over a year. During the conversation the facility administrator stated that Resident #1 was not issued a 30-day involuntary notice, no written correspondence was sent out to the resident's representative, nor the local State Ombudsman's office, nor sent with the resident to the hospital on 05/18/24. The administrator stated that there are no administrative staff in the facility during the weekend and 05/18/24 was a Saturday. In an interview with Resident #1's representative on 05/30/24 at 11:06 am, Resident #1's representative stated that S/he was never notified that the facility would not accept Resident #1 back to the facility after being sent to the hospital. Resident #1's representative also stated that S/he was not made aware the Resident #1 was no longer residing at the facility and that the facility would not take him/her back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Haven Nursing and Rehabilitation Ctr	701 Edmondson Avenue Catonsville, MD 21228

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 18819 Based on reviews of a complaint, a closed clinical record and staff interviews, it was determined that the facility failed to send a copy of the facility bed hold policy with a resident when the resident was sent to the emergency room . This was evident for 1 (Resident #1) of 3 residents reviewed during a complaint survey. The findings include: Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who is bed bound and demented. Resident #1 was evaluated in the emergency room and cleared for discharge back to the nursing facility on 05/19/24. The facility refused to allow Resident #1 to return to the facility after being evaluated and cleared in the hospital on 05/19/24. In an interview with the facility administrator and director of nurses (DON) on 05/28/24 at 10:30 am, during the conversation the facility administrator stated that Resident #1 was not issued a 30-day involuntary notice, no written correspondence was sent out to the resident's representative, nor the local State Ombudsman's office, nor sent with the resident to the hospital on 05/18/24. The administrator stated that there are no administrative staff in the facility during the weekend and 05/18/24 was a Saturday. A review of Resident #1's closed medical record on 05/28/24 failed to reveal Resident #1 was issued a copy of the facility bed hold policy upon being emergency petitioned to the hospital on 05/18/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Forest Haven Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Edmondson Avenue Catonsville, MD 21228	

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 18819 Based on reviews of a complaint, a closed clinical record and staff interviews, it was determined that the facility failed to permit a resident to return to the facility after a brief hospitalization . This was evident for 1 (Resident #1) of 3 residents reviewed during a complaint survey. The findings include: Review of complaint MD00205968 on 05/28/24 revealed an allegation that, on 05/18/24, Resident #1 was sent to the emergency room under emergency petition due to being witnessed for the second time in a 10-day period fondling the same female resident (hands down the resident's diaper) who is bed bound and demented. Resident #1 was evaluated in the emergency room and cleared for discharge back to the nursing facility on 05/19/24. The facility refused to have Resident #1 return from the hospital on 05/19/24. In an interview with the facility administrator and director of nurses (DON) on 05/28/24 at 10:30 am, the DON stated that the facility did not accept the resident back from the hospital for the safety of the female residents. The DON stated the facility was aware of Resident #1's sexual behaviors for over a year. During the conversation the facility administrator stated that Resident #1 was not issued a 30-day involuntary notice, no written correspondence was sent out to the resident's representative, nor the local State Ombudsman's office, nor sent with the resident to the hospital on 05/18/24. The administrator stated that there are no administrative staff in the facility during the weekend and 05/18/24 was a Saturday. A review of Resident #1's closed medical record on 05/28/24 failed to reveal Resident #1 was issued a copy of the facility bed hold policy upon being emergency petitioned to the hospital on 05/18/24. In an interview with Resident #1's representative on 05/30/24 at 11:06 am, Resident #1's representative stated that S/he was never notified that the facility would not accept Resident #1 back to the facility after being sent to the hospital. Resident #1's representative also stated that S/he was not made aware the Resident #1 was no longer residing at the facility and that the facility would not take him/her back.