STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation and interview it was determined the facility failed to ensure a safe, clean, comfortable, homelike environment. This was evident pervasively throughout all resident floors of the facility's building.The findings include: 1. On 9/4/25 at 8:14AM the surveyor observed ripped areas in the flooring material in resident room # 202.2. On 9/4/25 at 8:26AM the surveyor observed resident room [ROOM NUMBER] with windows with a cloudy, unclean appearance and chipping wall paint.3. On 9/4/25 at 8:30AM the surveyor observed resident room # 110 with 2 out of 2 windows with a cloudy, unclean appearance and the surveyor noted the window glass in 1 out of 2 windows in the room had a large v-shaped crack present, and the privacy curtain was observed to have an unclean appearance with multiple brown stains, and chipping wall paint was observed. One area of plank type flooring was observed to be mismatched and gray in color with the surrounding brown flooring.On 9/4/25 at 9:20AM the surveyor conducted an interview with the facility Administrator and shared the concerns at which time they acknowledged the surveyor's concerns and reported the following information: Let me call maintenance right away.4. On 9/4/25 at 9:30AM the surveyor observed gray marks on the Station 3 hallway walls. 5. On 9/4/25 at 9:35AM the surveyor observed resident room [ROOM NUMBER] with loose covering to the lower portion of the room door which was protruding with a bowed appearance and gray marks with a broken piece of the covering which was protruding outward. 6. On 9/4/25 at 1:15PM the surveyor observed resident room [ROOM NUMBER] with broken blinds.7. On 9/10/25 at 10:43AM the surveyor observed an area of brown colored peeling tape approximately 5 feet across and 2 inches wide with exposed wall mesh type material present above the facility's interior lobby doors.8. On 9/10/25 at 10:45AM the surveyor observed a missing end cap on the lower wall molding of the hallway near room [ROOM NUMBER].9. On 9/10/25 at 10:45AM the surveyor observed four areas of white spackling present on the wall next to the interior lobby doors and two different wall paint colors were both present with paint roller type marks present on the wall.10. On 9/10/25 at 10:48AM the surveyor observed the ceiling area by the interior lobby doors with approximately a 6 inch crack in the ceiling tile, multiple scratch marks present on the ceiling tiles, and a lifted ceiling tile.11. On 9/10/25 at 10:51AM the surveyor observed the community area next to the lobby with chipped paint present on the wall molding, a section of mismatched flooring, areas of white spackle present on the wall paint, 1 of 4 sitting chairs were observed to have a severely worn appearance with pieces of vinyl material hanging off and exposed under cloth material present, 1 out of 1 cushioned chair was observed with a severely worn appearance with the surface material worn off and peeling exposing the under cloth of the cushion with the seat cushion observed to be slanted and smushed down, and 1 out of 1 couch was observed soiled with black, brown, and red staining present on the material throughout.On 9/10/25 at 10:57AM the surveyor observed red stains present on the floor in front of the couch furniture in the community area next to the lobby.On 9/10/25 at 11:00AM the surveyor conducted an interview and a dual observation and shared concerns with Director of Housekeeping #8 who acknowledged and confirmed understanding of the surveyor's concerns and stated the following information to the surveyor: I see what you are seeing.12. On (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/10/25 at 11:05AM the surveyor observed 32 unpainted white spackled areas on the walls throughout the Station 3 hallway. Gray marks, scraping, and chipping paint were observed to be present around the elevator and molding near the elevator was observed to be damaged as well as the flooring in front of the elevator which had a worn and damaged appearance and was mismatched in color as compared to the surrounding flooring.13. On 9/10/25 at 11:08AM the surveyor observed areas of gray scrapes on the hallway walls between resident rooms #117 and # 119 and between resident rooms # 115 and # 117.14. On 9/10/25 at 11:09AM the surveyor observed a hallway handwashing sink with an unclean appearance and no trim molding present along the floor, with a cupboard which was missing hardware with 2 screws and holes present in the cupboard doors. Caulk material was observed surrounding the sink with a brown and unclean appearance.15. On 9/10/25 at 11:10AM the surveyor observed gray scrapes on the wall paint between resident rooms #107 and 109.16. On 9/10/25 at 11:12AM the surveyor observed a crack approximately 4 inches long in the ceiling tile in the hallway near resident room [ROOM NUMBER], and a lifted ceiling tile that was not flush with the ceiling.17. On 9/10/25 at 11:13AM the surveyor observed a ceiling tile which was bowed in appearance near resident room # 113 and a ceiling tile which was lifted in appearance near resident room [ROOM NUMBER], and a ceiling tile with a dark brown circular stain with a hole present in it near resident room [ROOM NUMBER]. A circular metal plate was observed screwed to the ceiling with an unclean gray appearance.Resident room # 111 was observed to have chipped areas of paint and black and gray marks on the lower portion of the room's door covering material.18. On 9/10/25 at 11:14AM the surveyor observed scrapes present on ceiling tiles located outside of resident room [ROOM NUMBER].19. On 9/10/25 at 11:16AM the door to resident room [ROOM NUMBER] was observed to have an area of damage to the wood.20. On 9/10/25 at 11:22AM the surveyor observed the windows in resident room [ROOM NUMBER] to be unclean and cloudy in appearance, and the wall behind the headboard of the bed was observed to have paint worn off in various areas.21. On 9/10/25 at 11:23AM the surveyor observed resident room [ROOM NUMBER] continued with broken and bent blinds. Unpainted/unfinished sections of wood wall molding which was mismatched in color to the existing painted section of molding present next to it were observed. Metal registers were observed below the windows to be bent and falling out of place with surrounding rusty brown metal material exposed. A pillow was observed laying on the floor and with no pillowcase. An interview of Resident #58 was conducted at this time and Resident #58 expressed to the surveyor that the conditions in the room had been present for a long time.On 9/10/25 at 11:26AM the surveyor shared concerns with Registered Nurse #11 who after surveyor intervention, stated: I'm putting in the TELS (computer program utilized by staff to inform maintenance of concerns) system.22. On 9/10/25 at 11:27AM the surveyor observed broken blinds in resident room # 107.On 9/10/25 at 11:27AM the surveyor observed that after surveyor intervention, cleaning was being performed to the community area furniture by Director of Housekeeping #8 and housekeeping staff.23. On 9/10/25 at 11:30AM surveyors observed an air conditioning unit in room [ROOM NUMBER] with duct tape present on each side of the air conditioning unit and a board which was taped to the window which had a dirty appearance with black, brown, and gray matter present on it. The residents' window view was unclean and cloudy in appearance with weeds observed within the window space. An electric vent labeled split-system heat pump with a buildup of gray matter within it was observed affixed to the wall. The flooring near the resident's bed was observed to be cracked.24. On 9/10/25 at 11:36AM surveyors observed a 6-inch x 3 inch area in resident room [ROOM NUMBER]'s door covering to be cracked. Further observation of room [ROOM NUMBER] revealed chipped paint present within the room, and a patchwork area on the lower portion of the wall near the bathroom which was approximately 3 feet tall x 2 feet wide with pieces of cove molding adhered to the wall in several areas with areas of smeared adhesive type material with cove molding at the base with a bowed appearance. An exposed area of broken drywall type material was observed present next to the patchwork area. The bathroom was observed to have gray scrape marks on the doors and along the wall across from the commode. Spackled screw holes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and an unpainted area was observed on the wall next to the toilet paper dispenser, and the seam along the wall was observed to be brown in appearance. The caulk surrounding the toilet base was observed to be missing in some areas and areas of dark brown staining were present. One ceiling tile in the bathroom was observed to have brown staining covering approximately 70% of the tile's surface. The wall behind the commode was observed to have an unclean appearance with various brown speckles present and a section of dry wall material to the right of the bathroom sink was observed to be in disrepair with a bubbled appearance and an area that appeared to be cut exposing a different material underneath and a smeared area of adhesive/spackle type material.25. On 9/12/25 at 9:19AM the surveyor observed pieces of the severely worn cushioned chair's surface material present on the floor in the community area next to the facility's lobby. The surveyor noted that multiple stains and discoloration of the couch's fabric throughout continued to persist after housekeeping staff had previously performed cleaning of the material in response to the surveyors sharing of concerns.Surveyors completed a tour of the facility to share maintenance concerns on 9/12/25 with Maintenance Director #18 beginning at approximately 9:45AM, in addition to other prior tours additionally performed with them. 26. On 9/12/25 at 10:43AM surveyors observed resident room [ROOM NUMBER]. The resident's sink vanity was observed to have a square shaped piece of wood material which was worn in appearance, attached to the front of the vanity by nails. Cracked areas were observed present between the vanity and the wall. The materials on the front of the vanity were observed to be mismatched. [NAME] cove molding was observed to be bowed in appearance and did not cover the flooring surface beyond where the flooring material ended. One bathroom ceiling tile was observed to be lifted in appearance and the metal grid holding the ceiling tiles was observed to have discolored areas with a rusty brown appearance. The bathroom lighting was observed to have a light fixture with two different colored bulbs present, one which was fluorescent and one which was a warm color. The cove molding in the bathroom was observed to be separated from the wall with duct tape present on it. Another section of the cove molding in the bathroom was observed to have various pieces of duct tape securing it to the wall. The handle covers present on the resident's toilet seat riser were observed with areas of worn off material.27. On 9/12/25 at 10:47AM surveyors observed resident room [ROOM NUMBER]'s bathroom which had wet brown liquid and areas of missing caulk surrounding the base of the commode. Cobwebs were observed in the corner of the ceiling in the resident's bathroom. The sink vanity was observed to have a worn appearance with two cupboard doors, one of which was missing a handle. Cove molding was observed at the base of the vanity to have a bowed appearance exposing flooring area with dark debris present. The light fixture located above the vanity was observed to have a pull cord approximately 2 inches in length which was difficult for the resident to reach. Surveyors observed a light fixture mounted on the wall located next to the resident's bed, however, the pull cord for the fixture was on the opposite side of the fixture, located away from the resident's bed and was not within reach of the resident when the resident was in bed. 28. On 9/12/25 at 10:50AM surveyors observed the room signage to resident room [ROOM NUMBER] with chipped areas present. 29. On 9/12/25 at 10:50AM surveyors observed a damaged area of ceiling with cracking present with a stained appearance surrounding the crack and staining and a bubbled appearance below the area on the wall in the hallway outside of resident room [ROOM NUMBER].On 9/12/25 at 10:50AM surveyors observed the room number signage to resident room [ROOM NUMBER] to be worn in appearance with splattering of white paint and chipping areas observed on it.On 9/12/25 at 10:50AM surveyors observed three different colored mismatched areas of handrails located across from resident room [ROOM NUMBER].30. On 9/12/25 at 10:55AM surveyors observed 18 out of 18 call bell light covers located in the 2A hallway with discoloration and brown staining present.31. On 9/12/25 at 10:50AM surveyors observed the 2A day room. Chipped paint and black marks were observed on wall surfaces, three tray tables were observed, one tray table with brown stains present and a dirty straw, one tray table with cracks present in the surface and crumbled areas along the edges of the tray table, and one tray table which was holding metal (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment and trash bags. The blinds were observed with a worn appearance with areas of chipping paint present on them. An unused bulletin board with staples present was observed sitting against the wall on the floor, and another bulletin board was observed to be blank with a torn paper covering present on it. A black plastic piece was observed secured to the wall with no phone present. A toilet seat riser and a hoyer lift were observed stored in the day room. One ceiling tile was observed with a brown half circle shaped stain present.32. On 9/12/25 at 10:51AM surveyors observed electrical panels on the first floor of station 2A containing breakers were openly accessible within the resident hallway and with a plastic container of personal protective equipment was located directly in front of the breaker box which had a sign posted which read the following information: CAUTION area in front of this electrical panel must be kept clear for 36 inches.33. On 9/12/25 at 10:52AM surveyors observed a dented doorknob in the first-floor hallway located on station 2A.34. On 9/12/25 at 10:54AM surveyors observed a section of missing ceiling tile in the hallway outside of resident room [ROOM NUMBER].35. On 9/12/25 at 10:54AM surveyors observed multiple resident room doors with various areas of worn sticker type adhesive present in the hallway of room [ROOM NUMBER].36. On 9/12/25 at 10:58AM surveyors observed dark brown staining present on ceiling tiles located just beyond the double door locked entrance to Station 1 (house). The interior surface of the double doors was observed to have large areas of scraping and missing paint present. The window to the nursing station visible from the resident's dining area was observed to have a peeling film appearance with the backs of nursing papers and tape and adhesive visible. Chipping wall paint was observed below the window area.37. On 9/12/25 at 10:58AM surveyors observed blue drip marks approximately 2 feet in length present along the hallway's mural on Station 1 (house).38. On 9/12/25 at 10:58AM the surveyors observed a bare appearing community room area which opened into and was visible from the resident community area with one table, no chairs or other furniture, 2 vending machines, a hand sanitizer fixture, and Heimlich maneuver poster. The room included several windows with a view of overgrown weeds, an exterior door with a rust-colored appearance, broken metal objects, a large wooden board which appeared to have partially rotted, and a piece of pvc pipe lying on the ground outside. 39. On 9/12/25 at 11:00AM surveyors observed an area of flooring on the first floor of Station 1 (house) near the elevator and outside of the bathroom with flooring which was observed to be in disrepair to include chipping areas with pieces missing, and lifting/bowed. The flooring material was felt to be movable when surveyors walked on it. Areas of the walls in this area were observed to be unfinished with paint and missing cove molding and peeling paint.40. On 9/12/25 at 11:06 AM surveyors observed the flooring in the hallway of the first floor of station 1 which had an area of disrepair and mismatched flooring. Observation of the first floor station 1 community area next to the nursing office was observed to have flooring that was severely worn with the surface color worn and chipping areas, and missing and broken blinds were present, and a window which had a white piece of board taped in place to cover the lower portion of the window was observed to have a bent metal covering to the windowsill which was separated from the windowsill. Window drapes at the top of the windows were observed to be hung in a bunched and uneven manner. [NAME] spackling was present on the wall in several areas next to the community room's bathroom. The nurses' station glass windows were observed to be unclean with a cloudy appearance. The ceiling was observed to be bowed in appearance with brown staining present on the ceiling tile where the metal sprinkler was located. Interior front doors to the station 1 house were observed to have areas of scraping and worn off paint. The flooring in front of the interior front doors to the station one house were observed to be mismatched in color and type and an area was missing a piece of flooring. A vent was observed above the interior front doors to the station one house which was covered in gray matter.41. On 9/12/25 at 11:14 AM surveyors observed resident room # 2 with broken blinds and no privacy curtains for two out of two residents in the room. One light fixture was observed to be loose hanging from the wall with a 2-inch cord present. Areas of scraping and chipped paint were observed on the walls of the room and on a door located within the room which did not have a door handle present and where the door handle (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would be located, a hole was observed. Screens on both sides of the air conditioning unit located within the window of the room were observed to have open areas unscreened to the outside. The glass type material in the windowpane of the window was observed to be cracked. Flooring tiles were observed by surveyors to be lifted out of their areas and laying on the floor.42. On 9/12/25 at 11:15 AM surveyors observed cracking in the wall above the glass window in the hallway near the nurse's station. Walls located next to the nursing station in the hallway were observed to have areas of different colored paint and several walls were unclean in appearance with brown drip marks present and multiple plastic anchors were observed protruding from the wall.43. On 9/12/25 at 11:16 AM surveyors observed a nutrition area located in the resident hallway of station 1, floor 1, which included a wall mounted cupboard with doors which were nailed shut and a seam on the wall below the cupboards was exposed. A mismatched piece of wood was observed nailed to the front of the nutrition station area below the countertop, next to the nutrition refrigerator. A section of flooring below the nutrition refrigerator was observed to be missing exposing other flooring type with broken materials.44. On 9/12/25 at 11:16 AM surveyors observed a hand washing sink area located in the hallway of station 1, floor 1 which was observed to be in disrepair with crumbling slash peeling areas and missing hardware. The wall located behind the faucet was observed to be discolored and unclean in appearance. Cracking was observed in the caulk surrounding the hand washing countertop. The corner molding next to the hand washing sink was observed to be separated. A large crack was observed in the wall of the resident hallway extending from the molding upward above the fire pull station and worn paint was observed on the wall in this area.45. On 9/12/25 at 11:17AM surveyors observed white plastic corner molding hanging loosely off of a wall corner in the station 1, floor 1 resident hallway near resident room [ROOM NUMBER]. Flooring tiles within resident room [ROOM NUMBER] were observed to be mismatched in color, and there was no threshold strip located between where the hallway flooring ended and the square tile flooring to the resident room began. The doorway area to resident room [ROOM NUMBER] was observed to have an unclean, dark worn adhesive type material present. Resident room [ROOM NUMBER]'s window glass was observed to be cloudy and unclean in appearance. Metal material was observed sticking upward from the windowsill. Dark areas of staining were observed on the surrounding window surface. One white, jagged piece of white colored hard material was observed nailed to the corner of the windowsill, and worn duct tape was observed extending from the window sill upward. Areas in the corners of the window were observed with cracking and peeling. A gray cobweb approximately 1 foot in length was observed hanging in the corner of the ceiling of the room. Pieces of unfinished wood were observed screwed to the ceiling supporting the metal for the privacy curtain to hang on.46. On 9/12/25 at 11:23AM surveyors observed the second floor of station 1 (house). Flooring was observed with areas where the surface color was worn off, and areas of chipping.47. On 9/12/25 at 11:23AM surveyors observed resident room [ROOM NUMBER] which had an area of mismatched, uneven, wood filler type material smeared with a rough appearance on the resident's door and over the area below the door hinge. Splintered wooden areas were observed to be present on the door frame to the room. Surveyors observed cracked and broken flooring leading to the entrance to the resident's room, with approximately a 0.5-inch depressed area. The flooring leading into the room was observed to have an unclean appearance with grey and brown debris present. A piece of furniture with a visibly worn surface was observed in the room with one drawer mismatched in color to the remaining four drawers with one drawer missing the handle with a broken piece of handle protruding from the drawer. Several areas of paint were observed to be worn off on the wall near the light fixture.48. On 9/12/25 at 11:24AM surveyors observed the resident bathroom located near resident room [ROOM NUMBER] which was observed to be unclean in appearance with brown debris on the wall, the toilet was observed to be mounted diagonally and close to the wall. Paint on the walls was observed to be patched with different colors, and chipping paint was observed to be present. [NAME] debris was observed present on the bathroom floor and surrounding the entrance to the bathroom and along the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wall which was observed with no cove molding present. Dark stained areas were observed to be present surrounding the base of the commode. Molding located behind the toilet was observed to be cracked with separation present. The upper portion of the side of the bathroom vanity was observed to be damaged with separated covering material with exposed particle board type material with a white fuzzy substance observed within it. The lower portion of the side of the bathroom vanity was observed to be damaged and lifted upward. No sink stopper was present within the sink.49. On 9/12/25 at 12:12PM surveyors observed a handrail next to the 2A community room with no cap, exposing a sharp metal surface. Surveyors shared the concern with Director of Maintenance # 18 who observed, acknowledged and confirmed understanding of the concern.50. On 9/12/25 at 12:14PM surveyors observed the shower room located near the elevator on the first floor of station 1 (house) which was observed to be in disrepair. The handwashing sink vanity was observed to have an area of damaged wood laying beneath it with dark debris present. An area of disrepair was observed to the right of where the handwashing sink was attached to the wall with a dark gray and rough appearance, the left side of the vanity was observed to be separated from the sink top, with a crumbled and peeling appearance, the area above the entrance to the restroom on the wall was observed to have cracking present and white spackled areas. The area of wall located next to the fire extinguisher signage was observed to be cracked extending from the door frame to the ceiling.51. On 9/12/25 at 12:15PM surveyors observed a hallway electrical outlet with no cover present, with gray matter present. A wall corner was observed in the hallway with a cracked and damaged appearance with exposed metal present.52. On 9/12/25 at 12:16PM surveyors observed countertop covering to the side of the countertop above the nutrition refrigerator on the first floor of station 1 (house) was broken.53. On 9/12/25 at 12:19PM surveyors observed broken wood covering present on the lattice within the station 1 community area.54. On 9/12/25 at 12:20PM surveyors observed room [ROOM NUMBER] on the first floor of station 1 (house) with broken blinds, crumbled areas on the furniture surface, a cracked window pane, the window was observed and felt to be movable and not secured, a piece of bent metal flashing hanging from the base of the window sill near the floor which was protruding outward next to the resident's bed. The overbed table was observed to have an unclean surface. A damaged thermostat was observed mounted on the wall with a plastic covering hanging off of and lifted out of the wall with plastic anchors visible. room [ROOM NUMBER]'s signage did not identify which bed the resident was located in. 55. On 9/12/25 at 12:21PM surveyors observed an area outside of resident room [ROOM NUMBER] on the wall with an area of peeled and missing paint in which the brown wall board was exposed.56. On 9/12/25 at 12:21PM surveyors observed resident room [ROOM NUMBER] with mismatched colors of flooring which appeared to be unclean with brown debris present. A section of flooring was observed to be lifted and out of its place, laying on the floor. Broken and splintered wood was observed on a lattice type covering within the room. Chipping and cracked paint were observed in several areas within the room to include a pipe running along the floor, the wall below the windowsill and additional wall areas. Blind panels were observed to be broken and with missing sections of panels. Resident wardrobe furniture was observed to be missing a drawer and hardware, and the bottom of the furniture appeared to be in disrepair as well as the drawer that existed was observed to be broken. Surveyors observed that two out of three residents had no privacy curtain present. Bent areas of metal windowsill material were observed. An area was openly exposed to the outside between the window and the covering extensions of the window ac unit. Dark debris was observed on areas of the window and windowsill. Window glass privacy covering was observed with scratched off areas.57. On 9/12/25 at 12:23PM surveyors observed broken ceramic pieces sticking out several inches long from the wall in the resident hallway on the first floor of station 1 (house).58. On 9/12/25 at 12:23PM surveyors observed the fluorescent lighting in the ceiling next to the stained ceiling tile containing the metal sprinkler on the first floor of the station 1 community area. The fluorescent lighting was observed to be lifted in the area with the bowed appearance in the ceiling which exposed approximately an inch of metal that was observed with a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	black, thick layer of debris present.59. On 9/12/25 at 12:24PM surveyors observed cove molding missing on a wall corner near the room labeled Station 1 Unit Manager.60. On 9/12/25 at 12:25PM surveyors observed that room [ROOM NUMBER] had no signage except the number 12 written in pen on the wall which was surrounded by chipping drywall material and ripped areas of brown exposed wallboard. room [ROOM NUMBER] was observed to have denting in the walls and an area of damage which included cracked paint and drywall, and depressions in the wall. Blinds were observed to be damaged and missing in sections. The light fixture above the bed was observed to have speckled areas of rust color. The mirror type material on the wall was observed to be unclean with various gray smears present.61. On 9/12/25 at 12:27PM surveyors observed two diagonal cracks present in the wall and separation present between where the wall met the ceiling on the second floor of station 1 (house) resident hallway.62. On 9/12/25 at 12:27PM surveyors observed an area between a door frame and the wall to have multiple broken and crumbled several inch sized pieces of building material present on the second floor of station 1 (house).63. On 9/12/25 at 12:28PM surveyors observed the second-floor station 1 (house) shower room signage in the resident hallway with missing letters and a worn appearance in areas on the surface of the door and door frame. Black scraping was observed to be present on the wall next to the shower room. Within the shower, a metal folding chair with plastic was observed to be situated in the shower for a seat. The vent labeled NuTone within the bathroom was observed to be covered with a layer of thick grey debris. The soap dispenser was observed to have rust-colored stains present.64. On 9/12/25 at 12:29PM surveyors observed the second-floor station 1 (house) bathroom which was observed to have dark areas present surrounding the base of the commode, the side of the bathroom vanity with exposed particle type board present, and 1 of 2 knobs was present on the vanity doors.65. On 9/12/25 at 12:29PM surveyors observed a ceiling tile in room [ROOM NUMBER] with a dark brown stain present.66. On 9/12/25 at 12:30PM surveyors observed room [ROOM NUMBER] with cracking in the wall's surface which extended upward from near the floor to near the ceiling. Cracks were observed in the ceiling and where the wall met the ceiling. Flooring near this area was observed to have a bowed appearance. A small nightstand piece of furniture was observed with wear to the wood-colored surfaces. Sections of flooring in the room were observed to be mismatched in color and cracking was observed within the wall which held a wooden fireplace mantel. Above the mantel was an area of wall damage present with chipping paint and exposed brown material. Sections of window blinds were observed to be missing. Another crack in the wall was observed extending above the resident's light fixture up toward the ceiling. Cracking in the wall was observed above the resident's bedroom window.67. On 9/12/25 at 12:32PM surveyors observed an uncovered area in the resident hallway below the signage to room [ROOM NUMBER] with uncovered wiring. Gray marks were observed on the wall.68. On 9/12/25 at 12:32PM surveyors observed broken and mismatched areas of flooring in the resident hallway outside the shower room near room [ROOM NUMBER].69. On 9/12/25 at 12:32PM surveyors observed the flooring to room [ROOM NUMBER] to be sloped and felt soft when walked upon. Flooring tiles located near the window sill were observed to have darker staining present.70. On 9/12/25 at 12:33PM surveyors observed and felt areas of flooring material which were raised with an uneven surface outside of the resident bathroom on the second floor of the station 1 (house) hallway. Throughout the tour with Maintenance Director # 18 they acknowledged and confirmed understanding of the surveyor's concerns.On 9/15/25 at 9:25AM surveyors conducted a tour of the facility including the facility's Administrator and Maintenance Director #18 to share surveyor concerns. During the tour, surveyor concerns were acknowledged by both the facility Administrator and Maintenance Director #18.On 9/15/25 at 9:25AM the facility Administrator stated that the flooring located on floor 1, station 1 outside the elevator got replaced not long ago. The handle to the shower water was observed and felt to be movable and separating from the wall, at which time the facility Administrator stated: I'm seeing that now moving, so we are going to fix that.On 9/15/25 at 9:30AM after surveyor intervention, the Director of Maintenance stated to the Administrator in the presence of surveyors that they (facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff) are working on hanging privacy curtains now. After surveyor intervention, the Administrator informed a staff member that the window to the nursing station needed cleaning, to which they replied: Housekeeping does that. 71. On 9/15/25 at 9:35AM a metal plate with a cut out sharp edge was observed on a door within the first floor station 1 (house) hallway and both the Administrator and Director of Maintenance #18 confirmed with surveyors that this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to: 1.) ensure proper sanitation and food handling practices, 2.) properly monitor the temperatures of nourishment refrigerators, and 3.) ensure labeling and dating of food products and monitoring for expiration of food product. This was evident during the surveyor's tours of the facility's kitchen during the facility's recertification survey. The findings include: 1. On 9/4/25 at 7:46AM the surveyor conducted an initial tour of the facility's kitchen. On 9/4/25 at 7:47AM the surveyor observed the reach in refrigerator with an unclean appearance. Black debris and food crumbs were observed in the bottom of the reach in refrigerator and the racks holding containers of food items were observed to have missing areas of paint. The surface of the walls within the reach in refrigerator had an unclean appearance with brown debris present. The handles to the reach in refrigerator were missing coverings revealing sharp edges. One unlabeled container of salad was observed to be present on the shelf within the reach in refrigerator with a condiment packet within it resting on the lettuce. At this time, the surveyor requested and conducted a dual observation of concerns with Dietary Director #5. On 9/4/25 at 7:49AM the surveyor observed the walk in refrigerator's exterior thermometer to be in broken condition and reading below -40 degrees. On 9/4/25 at 7:49AM a container of Worcestershire sauce was observed to have dark rings within the container and white debris present on the outside of the container. On 9/4/25 at 7:51AM the surveyor observed an air filter with a thick layer of gray fuzzy debris located directly above the ice chest in the kitchen where ice was observed to be stored below it. Dietary Director #5 observed and acknowledged the concern. On 9/4/25 at 7:52AM the surveyor observed individual plastic bags of lunchmeat and cheese sandwiches marked with use by dates of Tue 9/03 with condiment packages inside the packaging resting against the sandwich bread which was located within the walk in refrigerator. On 9/4/25 at 7:52AM the surveyor observed a plastic container of hard boiled eggs with speckled debris on the top of the outside of the container which was labeled USE BY [DATE] Sat 25 in the walk in refrigerator. Dietary Director #5 observed and acknowledged the concern. On 9/4/25 at 7:54AM the surveyor observed two unlabeled saran wrapped packages within the walk in refrigerator, one containing hot dogs, and one containing French fry wedges. Dietary Director #5 acknowledged the concern, confirmed there was no labeling present, and was observed throwing the items away into the trash can. 2. On 9/4/25 at 8:01AM the surveyor observed a layer of brown and black debris and food crumbs present on the food serving line equipment on the shelving located below the steam table. A layer of tan crusted food debris was observed just below the food service line on the surface of the equipment. 3. On 9/4/25 at 8:03AM the surveyor observed a plumbing pipe below the three compartment sink which was dripping into a plastic hot food cover which was filled with clear liquid. 4. On 9/4/25 at 8:04AM the surveyor observed a layer of gray fuzzy matter present on various piping extending over and near the food service line. 5. On 9/4/25 at 9:36AM the surveyor observed a layer of gray and black debris present on a vent near the food serving line. All concerns were shared with Dietary Director #5 and dual observations of concerns were made with them. On 9/5/25 at 1:56PM the surveyor conducted an interview with Dietary Director #5 who after surveyor intervention, reported to the surveyor that they had cleaned the areas below the steam table and that the dripping pipe in the kitchen needed to be sealed by maintenance and he needed to check the status of the repair.6. On 9/11/25 at 9:38AM the surveyor observed debris continued to be present on the vent near the food serving line which was holding containers of food below it. A dual observation was conducted of the concern with Dietary Aide #31 who acknowledged and confirmed understanding of the concern. A dual observation was then subsequently conducted by the surveyor with Cook/Supervisor #32 who observed the concern and also acknowledged and confirmed understanding of the concern. 7. On 9/11/25 at 9:41AM the surveyor observed brown liquid pooling in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the bottom of the reach in refrigerator.On 9/11/25 at 9:42AM the surveyor conducted a dual observation of the concerns within the reach in refrigerator with Cook/Supervisor #32 who observed, acknowledged, and confirmed understanding of the concerns.8. On 9/11/25 at 9:45AM The surveyor conducted a dual observation of concerns with Dietary Director #5. On 9/11/25 at 9:51AM the surveyor conducted a dual observation with Dietary Director #5 and observed the walk-in refrigerator to have a dirty and unclean appearance to the flooring, with areas of black and brown matter, thick areas of food debris, and small pieces of trash present on the floor. Areas of chipped paint were observed on the walls of the walk in refrigerator. Separated areas along where the walls met the ceiling were observed with black and brown matter present. A crack was present in the ceiling of the walk in refrigerator and the ceiling was observed to have black speckled areas of matter present. 9. On 9/15/25 at 12:15PM the surveyor requested and conducted a dual tour of nutrition rooms with Dietary Director #5. On 9/15/25 at 12:18PM the surveyor observed the Unit 2A nutrition refrigerator which held outside resident foods with meat and dairy in disposable containers, cartons of juice, and other food items. On 9/15/25 at 12:21PM the surveyor noted the Unit 2A nutrition refrigerator was observed with no temperature log present. When the surveyor inquired to Dietary Director #5 as to how they monitored temperatures of nutrition room refrigerators, they reported to the surveyor that the nursing staff was responsible for the monitoring. Dietary Director #5 was observed asking Licensed Practical Nurse (LPN) #33 where temperature logs were located, at which time they proceeded to the medication cart and unlocked it, and removed the temperature log to show the surveyor and Dietary Director #5. On 9/15/25 at 12:21PM the surveyor and Dietary Director #5 observed the nutrition refrigerator log for Unit 2A which revealed the temperature log was labeled Medication Storage Monthly Temperature Log (v June 2021). The following information was observed to be handwritten on the top of the log: Nourishment log 2A September 2025. Further review of the log revealed the following temperature range guidelines on the sheet in which the surveyor noted included temperatures above 40F: Refrigerator temperature acceptable range 36F-46F, record exact temperature twice daily if too warm or too cold record in other section and notify DON, If frig temp is out of range, call vaccine manufacturer (see package insert in product box) for vaccines and for all other items call the pharmacy for guidance. At this time, the surveyor conducted an interview with LPN #33 who confirmed with and reported to the surveyor that a range of 36F to 46F was acceptable for the nutrition refrigerator temperatures with food in them. When the surveyor inquired to LPN #33 as to what types of items were stored in the nutrition room refrigerators, they reported that outside resident food, nutrition supplements, milk, and other food items were stored in them. At this time the surveyor conducted an interview with Dietary Director #5 who acknowledged that the temperature range being monitored was not acceptable for food storage and acknowledged understanding of the surveyor's concerns. On 9/15/25 at 12:37PM the surveyor conducted a dual tour of the Station 1 (house) nutrition refrigerator with Dietary Director #5. LPN #35 provided the temperature monitoring log for the refrigerator for Station 1 which revealed the temperature log was labeled Medication Storage Monthly Temperature Log (v June 2021). The following information was observed to be handwritten on the top of the log: Nourishment Station 1 September 2025. Further review of the log revealed the following temperature range guidelines on the sheet in which the surveyor noted included temperatures above 40F: Refrigerator temperature acceptable range 36F-46F, record exact temperature twice daily if too warm or too cold record in other section and notify DON, If frig temp is out of range, call vaccine manufacturer (see package insert in product box) for vaccines and for all other items call the pharmacy for guidance. At this time, the surveyor conducted an interview with LPN #34 who reported to the surveyor that the appropriate range for the nutrition refrigerator was 36F to 46F and showed the surveyor where that was written on the log. LPN #34 stated that anything above this range, we let maintenance know by using the TELS [system for reporting maintenance concerns to maintenance staff] system. When the surveyor inquired as to LPN #34 if they need to let the kitchen know when a refrigerator is out of the temperature range on the form, they stated to both (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the surveyor and Dietary Director #5: No we don't let the kitchen know, it gets put in TELS. LPN #34 reported the nourishment refrigerator was used if residents needed to store food, for juice, and sometimes milk. On 9/15/25 at 12:43PM the surveyor conducted a dual tour of the Station 2B nourishment refrigerator with Dietary Director #5. Frost build up was observed within a compartment of the refrigerator with brown staining present on a portion of the build up. An area of brown liquid was present within the refrigerator. Yogurt was observed stored within the refrigerator. At this time, the surveyor conducted an interview with LPN #35 who reported that the temperature range considered out of range and necessary to report for the nourishment refrigerator was below 40F, 40F or below, and 48F and above. On 9/15/25 at 12:44PM the surveyor observed the Station 4 nourishment refrigerator with Dietary Director #5. Two different temp logs were observed to be in use at the same time with two different temperature ranges listed on them for September 2025. The surveyor noted that both temperature logs were observed to be incomplete. Upon observation by the surveyor and Dietary Director #5 of the thermometer located within the Station 4 nourishment refrigerator, it was noted that the thermometer read 46F. Frost build up was observed within a compartment of the refrigerator with brown staining present. Yogurt was observed to be stored within the refrigerator. The surveyor conducted an interview with LPN #36 and inquired to them as to what temperatures would be considered out of range for the nourishment refrigerator in which they would need to alert someone, to which they replied: above 40F, 46F, anything below 36F, and above 46F. At this time, Dietary Director #5 stated to the surveyor that they would be letting maintenance know, and the contents of the refrigerator would be discarded. On 9/15/25 at 12:53PM the surveyor observed the Station 3 nourishment refrigerator temperature log with Dietary Director #5, which revealed the temperature log was labeled Medication Storage Monthly Temperature Log (v June 2021). The following information was observed to be handwritten on the top of the log: Nourishments #3 [DATE]. Further review of the log revealed the following temperature range guidelines on the sheet in which the surveyor noted included temperatures above 40F: Refrigerator temperature acceptable range 36F-46F, record exact temperature twice daily if too warm or too cold record in other section and notify DON. If frig temp is out of range, call vaccine manufacturer (see package insert in product box) for vaccines and for all other items call the pharmacy for guidance. Both the surveyor and Dietary Director #5 observed that recorded on 12 occasions throughout September 2025, the temperature of the nourishment refrigerator was recorded by nursing staff on 3 occasions at 42F. Two thermometers were observed to be present in the Station 3 nourishment refrigerator, one which was observed to read 46F, and another which was observed to read 52F. The surveyor asked for Registered Nurse (RN) #11 to read one thermometer temperature, and RN #11 reported to the surveyor that it was at 46F. Milk, juice, yogurt, previously opened supplements, and other items were observed stored within the refrigerator. On 9/15/25 at 1:00PM a carton of milk with an expiration date of 9/12/25 was observed within the refrigerator. Dietary Director #5 stated to the surveyor: It's out of date, and everything needs to be discarded, and was observed removing the carton of milk from the refrigerator. Dietary Director #5 observed and acknowledged and confirmed understanding of the surveyor's concerns and stated the following information to the surveyor: I'm going to take the refrigerator out of service and let maintenance know, as soon as I walk downstairs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observations, staff interviews and review of facility documents, it was determined the facility failed to implement, complete and accurately reflect a Facility Assessment regarding the facility's physical environment, equipment, and other physical plant considerations that are necessary to care for its population, as well as an evaluation of the facility building maintenance capital improvements, or structures. This was evident during survey with the potential to affect all residents. The findings include the following: During observational rounds of the facility and interview on 09/12/2025 at approximately 9:45 AM with Maintenance Director staff #18, the surveyor asked if there was a preventive maintenance plan in place for replacement or repairs of resident beds, resident furniture, electrical switches/outlets, painting of facility walls, condition of walls, condition of ceilings, conditions of floors, condition and functionality of showers, condition of building foundation, functionality of resident call bell systems and monitoring of decline of the overall facility environment. Maintenance Director staff # 18, responded to the surveyor's question by stating, no.During an interview on 9/15/25 at 11:23AM with Administrator staff #3 with the Director of Maintenance staff #18 present, the surveyor inquired as to if the facility had a preventative maintenance program, to which the Administrator replied in the presence of the survey team: No, we don't have one. During review of the Facility Assessment on 09/15/2025 at 3:45 PM revealed the facility is performing a Routine Preventive Maintenance Schedule on a daily, weekly and monthly basis. However, the facility could not provide evidence that this was being completed. Further review revealed that the Facility Assessment did not include an evaluation of building maintenance capital improvements or structures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview with staff, it was determined that the facility failed to: 1) ensure clean linen was handled and transported in a safe and sanitary manner. The was evident for 1 clean linen transportation cart observed; and 2) establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice was evident for the Water Management Plan investigated during the survey.The findings include: 1. On 9/5/2025 at 6:30AM, the Surveyor observed Staffing Coordinator #24 pulling a 2-shelf cart with blankets piled one on top of the other on the top and bottom shelf of the cart. The blankets were uncovered and 2 brown blankets, on the bottom shelf, were dragging on the floor as the staff pulled the cart onto the basement elevator. The Surveyor asked, Are the blankets clean? Staffing Coordinator #24 responded Yes. The Surveyor asked, Should the blankets be covered? Staffing Coordinator #24 replied, I know, I know. She's getting me a bag. The Surveyor observed another staff member give Staffing Coordinator #24 a large, clear plastic bag and remove the 2 brown blankets, that were observed dragging on the floor, from the bottom shelf of the cart. On 9/5/2025 at approximately 9:30AM, during an interview with the Nursing Home Administrator (NHA), the Surveyor expressed the concern that clean blankets were being transported uncovered and 2 brown blankets were observed dragging on the floor as staff #24 entered the basement elevator. On 9/8/2025 at approximately 2:00PM, the Surveyor reviewed an In-Service Summary and Attendance form completed on 9/5/2025 with the subject: Clean Linen Transportation. The in-service stated Clean linen must be transported in linen carts with covers in place. Only clean linen should be in linen carts. No personal items in linen carts. Nursing staff provided signatures on the form. 2. On 09/12/2025 2:50PM during facility record review of the 'Infection Control Log' received and interview with the ADON/Infection Preventionist Staff #4, it revealed the following for reporting period 7/1/25-7/31/25 with 3 episodes of pneumonia, and for reporting period 8/1/25-8/31/25 it revealed a potential spike of 6 episodes of pneumonia. Surveyor asked Staff #4 were they aware of water testing at the facility and the results; surveyor was told Yes. On 09/12/2025 3:00PM during facility record review of the Water Management plan received from Maintenance Director Staff #18 for the Infection Control Facility Task it revealed 'Legionella Analytical' water test results dated 7/17/25 of water sampled on 7/1/25 detected Total Legionella for 3 of the 7 sample areas reported as follows: 1st Fl. Kitchen Sink (Hot) at 12 CFU/ml; 2nd Floor Main Shower Room (Cold) 18 CFU/ml; and 1st Fl. Kitchen Sink (Cold) >300 CFU/ml. On 09/15/2025 11:04 AM during record review the of the Water Management Plan received at the Entrance Conference on 09/04/25 from NHA Staff #3 and a duplicate copy from Maintenance Director Staff #18 on 09/12/25 3:00 PM, after surveyor request for an updated copy if available. The 18-page document revealed the following items per page: 1. Water Management Program Team Roster 2. Water Management Program: Facility Information (listing Forest Haven Nursing Home demographic details, such as Name, Facility Description, Address, etc.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Water Safety Management Assessment & Plan (Date of Assessment: 11/20/21) 4. Water System Narrative Description: Detailed Pages 5-12. Water Flow Diagrams (8 pages of non-specific data for Forest Haven) 13. Water Management Program Control Measures Pages 14-15. Diagrams (2 pages of non-specific data for Forest Haven) 16. Water Management Program Validation Techniques On 09/15/2025 11:45 AM during interviews with Maintenance Director Staff #18 and NHA Staff #3, surveyor discussed concerns regarding the Flow Diagrams on pages 5-12 and 14-15 and asked were the diagrams specific to Forest Haven water flow system; Maintenance Director Staff #18 stated No. Surveyor asked if there was any other description of building water system using text and/or flow diagrams; Maintenance Director Staff #18 stated No, there are no Forest Haven specific flow diagrams. Surveyor expressed concern about the date of the assessment listed on page 3: Water Management Assessment & Plan as 11/20/21, despite the statement listed on the form Program review required at least annually and with qualifying event. On page 1: Water Management Program Team Roster reflects the responsible parties as follows: the NHA Staff #3 as Administrator, Maintenance Director Staff #18 as Maintenance Director, and ADON/Infection Preventionist Staff #4 as Infection Preventionist. Of note, surveyor was informed of the hire dates of the responsible parties on the Team Roster as follow; NHA Staff #3 stated NHA Staff #3 arrival-[DATE]; Maintenance Director Staff #18-May 2025; and ADON-Infection Preventionist Staff #4-[DATE]. Surveyor asked when the last water management plan reviewed, or assessment was completed; Maintenance Director Staff #18 stated site water testing was recently completed on 7/1/25 by EcoLab and results received on 7/17/25 revealed 3 of 7 samples with positive findings of Legionella detected. Surveyor asked Maintenance Director Staff #18 once the results were known, was this considered a qualifying event and was the Water Management Program reviewed or updated at that time; surveyor was told No, I was told to run the water daily and retesting was recently completed on 9/2/25, we are waiting results. Of note, the facility was unable to provide further evidence whether the facility implemented adequate prevention and control measures once the water testing issue was identified. Additionally, the facility was unable to provide an updated Water Management Plan or Flow Diagrams specific to facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, record review, and interviews, it was determined that the facility failed to: 1) maintain laundry equipment in safe operating conditions. This deficient practice was evident for 1 of 4 washers and 4 of 5 dryers within the Laundry Room; and 2) maintain patient care equipment in a safe operating condition. This was evidence for 1 out of 4 Automatic External Defibrillators reviewed. The findings include: 1. On 09/12/2025 9:00 AM during record reviews and interviews pertaining to Complaint #309947 received on 5/21/25, it revealed the washing machine was broken, and we had to take the clothes home to wash them. During the interview the family stated that they were told during this time the machines were down but was never informed that the facility could still wash the resident clothing. Additionally, the family also shared they were never informed when the services resumed. On 09/12/2025 9:38 AM during observational rounds and interviews with the Director of Housekeeping/Laundry Account Manager Staff #8 in the Laundry Room, it revealed 1 of 4 washers and 4 of 5 dryers were out of service. The surveyor asked about the length of time the machines have been out of service. Staff #8 stated one washer has been out of service for over 3 years and of the remaining 4 washers, a 2nd washer was down from 5/9/25 to 5/13/25 for 5 days. During the days the washer was down and only 2 were working, the facility activated an off-site laundry plan. Currently 3 washers of the 4 are working. Staff #8 also advised for the dryers, 3 of 5 dryers have been out of service for over 3 years and are used just for spare parts. Another dryer (Dryer #1) went out of service on 7/10/25, the Maintenance Director (Staff #18) was notified. On 9/10/25, after a vendor service call, we were told the dryer needed several repaired. Currently there is no date of when the dryer will return to service, and 1 dryer is in use. The surveyor asked how the down machines impact the washing of resident personal clothing and Staff #8 stated resident clothing could still be cleaned, but there may have been delays. The surveyor shared the family concerns of Complaint #309947 and family being told machines were down. The Surveyor asked how updates about laundry services are communicated to the staff and families; Staff #8 stated I inform the nurse of the unit, not the GNAs or families. On 09/12/2025 1:25 PM during interview Maintenance Director Staff #18, surveyor shared concerns of multiple dryers and the 1 washer currently down. The surveyor requested the preventative maintenance logs or repair logs of the laundry equipment; none was provided for further review. On 09/15/2025 6:15 PM during interview with NHA Staff #3 the surveyor shared concerns regarding the multiple dryers and the 1 washer currently down and the lack of preventive maintenance or repair logs. Staff #3 stated those machines have been down for over 3 years; they are just used for spare parts. The facility could not provide any further supportive evidence about the length of time the equipment was not being used or plans to support the continued laundry needs of the facility. 2. Automatic External Defibrillator (AED) is a device that delivers an electric shock to the heart to restore a normal rhythm during a sudden cardiac arrest. On 9/10/2025 at 12:28PM, during a tour of Station 3, the Surveyor discovered an AED device located inside a locked container hanging on the wall outside of the nursing station. The container cabinet window had a clear, transparent, glass-like material which was cracked with sharp edges. The AED was inside the container in a blue case. There was no visible expiration date. The status indicator or ready green light was not on. Instead, there was a red indicator with a black X on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/2025 at 12:33PM, during an interview with Unit Manager/ Licensed Practical Nurse (LPN) #6 on Station 3, the Surveyor was informed that the maintenance department was responsible for routine inspections of the AED devices to ensure they are ready to use. There were 4 AED devices located by the nurses' stations on Station 2A, 3, 2B, and 4. The Surveyor and LPN #6 viewed the AED device on Station 3 and confirmed by visual inspection, the AED was not ready to use. The visual readiness indicator green light was not on and the red indicator with the black X was present. The glass-like material of the container window was cracked and broken with sharp edges. LPN #6 stated that she did not know the AED was not ready to use and container window was broken and would inform the maintenance department. On 9/10/2025 at 1:16PM, the Surveyor observed Maintenance Assistant #7 repairing the AED container window on Station 3. The Surveyor asked the status of the AED inside the container. Maintenance Assistant #7 was unsure how to check the status of the AED, did not know what the red indicator with the black X meant, and could not tell the Surveyor if it was ready to use. Maintenance Assistant removed the AED from the container. The AED made a beeping noise. During an interview with Maintenance Director #18 and the Director of Nursing (DON) at Station 3, the Surveyor informed the staff of the AED findings on that unit. The Surveyor, Maintenance Director #18, and the DON visually inspected the AED. The Surveyor expressed the concern that the visual readiness green light indicator was not on, there was a red indicator with a black X, there was no visual expiration date, and there was a beeping noise which indicated a problem and the AED would not be ready to use in the case of an emergency. The DON opened the blue case the AED was in. The chest pads needed to be replaced. The Surveyor confirmed the AED was not ready to use. The DON stated that the maintenance department was responsible for completing visual inspections of the AED's throughout the facility. The Surveyor stated that Maintenance Assistant #7 stated he did not know how to check the status of the AED devices and was could not tell the Surveyor when an AED is ready to use. The Surveyor also informed the staff that maintenance assistant #7 just fixed the container window which was cracked with broken, sharp edges. Maintenance Director #18 informed the Surveyor that he had been aware of the condition of the container window. Maintenance Director #18 stated that he would address the concerns with the AED promptly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined that the facility failed to ensure that the resident's call system was functioning properly. This was found to be evident for 2 resident rooms (room [ROOM NUMBER] and #218) out of 17 rooms observed at Station 4 and 3 resident rooms (room [ROOM NUMBER], #2 and #8) out of 13 rooms observed at Station 1. The findings include: 1. On 9/12/2025 at 2:47PM, 4 Surveyors toured Station 4 nursing unit. An observation was made of the call system at the nursing station and room [ROOM NUMBER]. A Surveyor observed the nursing station call system, there was an audible beeping noise coming from the call system, but no room number illuminated to indicate which room needed assistance. As the other Surveyors walked through the hallway, no light above any room illuminated to indicate which resident room needed assistance. Geriatric Nursing Assistant #23 was observed walking out of room [ROOM NUMBER], Resident #107's room. The Surveyor asked GNA #23 if Resident #107 had pressed the call bell for assistance. GNA #23 stated that the resident did press the call bell and the GNA was responding to the call to see if the resident needed assistance. The Surveyor requested the GNA #23 to ask Resident #107 to press the call bell again. Resident #107 pressed the call bell. The Surveyor, at the nursing station by the call system, could hear the beeping noise but there was no room number illuminated to identify which resident room needed assistance. The other 3 Surveyors in the hallway did not see any lights above any resident rooms light up to identify what resident in what room needed assistance. During an interview with GNA #23, the Surveyor was informed that the GNA knows that Resident #107 in room [ROOM NUMBER] needs assistance when they can hear the beeping noise at the nursing station and do not see a light illuminated above any other room. All other rooms light up, except room [ROOM NUMBER], when the resident presses the call bell. The Surveyor expressed the concern that the call system at the nursing station failed to illuminate for room [ROOM NUMBER]; however, there was an audible noise heard at the call system. The Surveyor also expressed the concern that the light above room [ROOM NUMBER] failed to light up when the resident pressed the button. GNA #23 confirmed the Surveyor's findings and stated that the light at the nursing station call system and above room [ROOM NUMBER] had not been working properly for months now. The light above room [ROOM NUMBER] would work on and off, but not consistent and Maintenance had been made aware. 1a. On 9/12/2025 at 2:50PM, during a continued observation of the call system at Station 4 nursing station, the Surveyors tested the call bells for other rooms. A Surveyor pressed the call bell for room [ROOM NUMBER], and the light above the room illuminated. Another Surveyor observed the call system at the nursing station. An audible beeping noise was heard from the call system at the nursing station; however, room [ROOM NUMBER] illuminated on the call system. GNA #23 and the Surveyors confirmed that when the call bell was pressed in room [ROOM NUMBER], room [ROOM NUMBER] illuminated on the call system. There was no room [ROOM NUMBER] on the call system at Station 4 nursing station. 1b. During a tour of Station 4 and interview with Maintenance Director #18 and the Nursing Home Administrator (NHA) on 9/15/2025 at 10:37AM, the Surveyor expressed the concern that when Resident #107 pressed the call bell for room [ROOM NUMBER], the call system at the nursing station failed to illuminate; however, there was an audible beeping noise heard coming from the call system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Surveyor also expressed the concern that the light above room [ROOM NUMBER] failed to light up when the resident pressed the call bell. During the interview, the Surveyor observed Maintenance Assistant #7 exiting room [ROOM NUMBER]. Maintenance Assistant #7 stated that the light above the door was fixed. Maintenance Assistant #7 and Maintenance Director #18 stated that they will address room [ROOM NUMBER] failing to illuminate on the call system at the nursing station. During a continued interview with Maintenance Director #18 and the NHA, the Surveyor informed the staff that when the call bell was pressed in room [ROOM NUMBER], room [ROOM NUMBER] illuminated on the call system. There was no room [ROOM NUMBER] on the call system at Station 4 nursing station. The NHA and Maintenance Director #18 confirmed the Surveyor's findings. 2. On 9/12/25 at 11:17AM surveyors observed Room # 4 on the first floor of station 1 and randomly tested the call bell nearest to the room's entrance door and observed that the call bell was not in working order, when the call bell button was pressed, it did not light the hallway call system. Director of Maintenance # 18 acknowledged understanding of the concern and reported to surveyors that they would get the call light fixed. 2a. On 9/12/25 at 12:20PM Surveyors observed room [ROOM NUMBER] on the first floor of station 1 (house). The call bell indicator light above the doorway in the resident hallway did not have a cover on it, the small light bulb was observed protruding from the mounted system. 2b. On 9/15/25 at 10:31AM surveyors observed the Station 1 second floor call bell system located in the resident hallway and observed that several call bell indicator lights on the system were missing plastic caps and failed to identify which room was calling for assistance which included room [ROOM NUMBER]. room [ROOM NUMBER]'s call light indicator had no cap and additionally, no light bulb present. On 9/15/25 at 10:31AM Certified Medication Aide #38 observed the call light system concerns with surveyors and acknowledged and confirmed understanding of the surveyor's concerns. During an interview on 9/15/25 at 11:23AM the surveyor inquired to the facility's Administrator with the Director of Maintenance #18 present, as to if the facility had a preventative maintenance program, to which the Administrator replied in the presence of the survey team: No, we don't have one. The Administrator stated the following information in response to the surveyor's inquiry as to if they felt that two maintenance staff were enough to cover the facility's environment needs: Well, the structure of the building is old, it's not an excuse, we've always run the maintenance department with two staff, we have two and a half people now, but we've always run it with two. At this time the surveyor offered to the Administrator and Director of Maintenance an opportunity for any questions regarding environmental concerns and they had no questions regarding the surveyor's environmental concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interviews with staff, it was determined that the facility failed to ensure the exterior facility environment was maintained to be safe, sanitary. This was evident throughout the surveyors' tour of the exterior facility. The findings include: On 9/10/25 at 9:13AM the surveyor conducted a tour of the facility's exterior environment. 1a. On 9/10/25 at 9:13AM the surveyor observed a piece of white painted wooden board affixed to the front of the facility's entrance with visible black nails around the perimeter of the board, and several weeds sticking out from the side of the board. 1b. On 9/10/25 at 9:13AM the surveyor observed uneven depressed areas of missing and misplaced bricks at the entrance to the facility's main parking lot with weeds present, and felt movable bricks upon walking in the parking lot leading up to the concrete sidewalk near to the front doors of the facility. Weeds were observed present along the concrete sidewalk at the front entrance of the facility. 1c. On 9/10/25 at 9:14AM the surveyor observed sections of fencing along the front of the facility in disrepair and damaged in multiple areas. Broken railings were observed, railings were observed falling out of place with some resting on the ground, and some were observed to be half in place and half resting onto the ground. Various caps to the fencing were mismatched in appearance with some being flat, and some being pointed. One fence cap was observed to be broken with sharp edges protruding upward. [NAME] matter was observed on the white fencing. A broken area of white fencing post was observed sticking out of the ground along the front of the facility. A fence post was observed to be falling onto the ground next to the facility's tattered job fair signage affixed to the fencing. 1d. On 9/10/25 at 9:15AM the surveyor observed brown plant matter which was dry in appearance protruding upward from the facility's gutter above the facility signage on the front of the building. 1e. On 9/10/25 at 9:16AM the surveyor observed a broken glass window with tape on it from the facility's exterior grounds. Weeds were observed protruding from the facility's shrubs in front of resident room windows. 1f. On 9/10/25 at 9:16AM the surveyor observed an area on the roof of the facility with lifted and missing shingles with shingles hanging down from the roof with areas of black roofing material and an area of wood exposed. Resident and community area windows were visibly soiled and cloudy in appearance from the exterior. Dried brown vines were observed on the exterior of the facility's wall. Approximately ten cobwebs were observed on the exterior of the second floor window where the vending machine was observed. Broken blinds were observed from the facility's exterior. One window screen was observed on the ground below a window with no screen present in it. 1g. On 9/10/25 at 9:19AM the surveyor observed the carport type area in front of the facility to have a gray film present with columns which were observed to have cracked and chipping areas of paint and orange rust colored spots. 1h. On 9/10/25 at 9:20AM the surveyor observed various plastic covers below resident windows with a thick layer of brown debris present on them, and a dirty brief resting on the ground. An area beneath (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident window was observed with white fencing missing on the top railing, and a pile of broken railing pieces and debris was observed on the ground with a gray colored wood piece resting against the side of the facility. On 9/10/25 at 9:43AM the surveyor requested and completed a tour of the exterior facility environment and shared concerns with the Director of Maintenance #18 and the facility's Administrator. During the tour, both the Director of Maintenance and facility Administrator acknowledged understanding of and observed the surveyor's concerns. Director of Maintenance #18 reported to the Administrator that brackets needed to be put back into the fencing because when they put the fencing rails back into place, they fall back out. The facility Administrator stated to the surveyor that a quote for gutter cleaning had been obtained last month, however, this was not scheduled. The facility Administrator stated to the surveyor during the tour that they will have the windows cleaned inside and out, and a power washing company would be contacted to clean the building's exterior, and a lawn company would be called for the weeds, and the front door area was a work in progress. Director of Maintenance reported to the surveyor in response to the groundskeeping regarding weeds that they would have to call the landscaping company, and would remove the pile of broken fencing and wood. In response to the sharing of the shingles in disrepair, the Administrator stated the following information: I haven't taken notice to it. During an interview on 9/15/25 at 11:23AM the surveyor inquired to the facility's Administrator with the Director of Maintenance #18 present, as to if the facility had a preventative maintenance program, to which the Administrator replied in the presence of the survey team: No, we don't have one. On 9/15/25 at 11:26AM the surveyor attempted a phone call to the facility's Regional Director of Maintenance and no response was received. As of 9/22/25, there continued to be no response received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure a handrail was firmly secured. This was evident for one handrail during a random observation on Station 3 during the surveyor's initial tour of the facility. The findings include: On 9/4/25 at 9:30AM the surveyor observed a handrail with a sharp edge present with a metal screw protruding from the wall in the hallway next to room [ROOM NUMBER]. The cap to the handrail was observed sitting on the opposite railing across the hall. Upon further inspection of the handrail the surveyor found the handrail to be loose and movable. On 9/4/25 at 9:34AM the surveyor conducted an interview and shared concerns with Unit Manager, Licensed Practical Nurse #6 who observed, acknowledged, and confirmed understanding of the surveyor's concerns and stated to the surveyor: Okay let me get maintenance, they replaced all this recently.On 9/4/25 at 9:36AM the surveyor shared concerns and conducted an interview with Maintenance Assistant #7, and after surveyor intervention, they reported the following information to the surveyor: We just fixed them, and they broke, We're gonna take care of that right now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, record reviews and interviews, it was determined that the facility failed to ensure resident self-determination for bathing preferences such as methods and times. This was evident for 1 (#114) resident out of 8 residents investigated during the survey.The findings include:On 09/04/2025 at 11:30 AM during initial observation and interviews, Resident #114 was observed in bed and shared with surveyor of never being allowed to shower and that staff always give a bed bath. Surveyor asked Resident #114 when they ask for a shower, what happens; resident stated they are told, there is no shower chair large enough and the bathing area is too small. Surveyor asked Resident #114 if they have ever been taken to the shower, Resident #114 stated no, I am only bathed in the bed and often the sink water is cold or not warm enough.On 09/09/2025 2:49 PM during record review it revealed on the Matrix POC (Point of Care) for the period of 8/10/25-9/9/25, only complete or partial bed baths were noted as being completed or offered. During this same time only one refusal of a bed bath was documented. The record review of the Care Plan entry for ADLs, revealed it was initiated on 8/25/19 and indicated no preference between bath and shower; no changes or updates to this non-preference or desire to shower were documented during subsequent reviews of the Care Plan for ADLs. Additionally, the record review of Shower schedule for Resident #114, indicated Monday and Thursday as shower days.On 09/09/2025 2:54 PM during observation and interviews with GNA staff #25 and LPN staff #27, surveyor shared Resident #114 concerns of request to take a shower and repeatedly told there was no shower chair to fit resident and bathroom area was too small. Surveyor accompanied GNA staff #25 and LPN staff #27 to Unit 2A shower room. Surveyor observed shower chair in room and LPN staff #27 stated this shower chair is regular sized and Resident #114 is unable to fit this chair or in this room. Surveyor asked if there was a larger shower chair and area for resident use if needed. Surveyor was then taken around the corner to Unit 3 and shown what was used as the larger shower area that is designated for the Bariatric Shower chair. Surveyor observed that the shower area had narrow doors like the initial shower area on Unit 2A, however there was a larger sized chair observed in the shower area; of note, this chair appeared too wide for the doors of the shower room. Surveyor asked how the Bariatric chair could fit through the doorway, LPN staff #27 stated after the resident is hoyered or assisted to the Bariatric chair, the chair is then turned sideways to enter the shower area for residents to be bathed. Surveyor asked if this had been attempted or offered for Resident #114, specifically on their assigned Monday and Thursday shower schedule days; GNA staff #25 stated no, that resident is always bathed in bed and never offered or taken for a shower. Surveyor asked LPN staff #27 if Resident #114 been offered to shower; stated that resident has history of refusing showers previously in the past when they were a resident on Unit 3. Surveyor asked LPN staff #27, how long had Resident #114 been on the current unit, LPN staff #114 stated a few months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record reviews and interviews, it was determined that the facility failed to notify the medical director of recent testing results of the facility when there was a need to alter treatment or testing significantly. This was evident for 2 (#113 and #1) residents out of 6 residents investigated during the survey.The findings include:On 09/12/2025 2:50PM during facility record review of the ?Infection Control Log' received from the ADON/Infection Preventionist Staff #4 for the Infection Control Facility Task, it revealed the following for reporting period 7/1/25-7/31/25 with 3 episodes of pneumonia with onset dates of 7/8/25; 7/16/25; and 7/21/25. For reporting period 8/1/25-8/31/25 it revealed a potential spike with 6 episodes of pneumonia reported with onset dates of 8/1/25; 8/4/25; 8/8/25; 8/14/25; 8/15/25; and 8/26/25.On 09/12/2025 3:00PM during facility record review of the Water Management plan received from Maintenance Director Staff #18 for the Infection Control Facility Task it revealed ?Legionella Analytical' water test results dated 7/17/25 of water sampled on 7/1/25 detected Total Legionella for 3 of the 7 sample areas reported as follows: 1st Fl. Kitchen Sink (Hot) at 12 CFU/ml; 2nd Floor Main Shower Room (Cold) 18 CFU/ml; and 1st Fl. Kitchen Sink (Cold) >300 CFU/ml.On 09/15/2025 3:30PM during record review and interviews with ADON/Infection Preventionist Staff #4 the surveyor requested documentation for the increased August 2025 pneumonia cases and any communication regarding the Water Management water testing results received on 7/17/25. Staff #4 stated a flu outbreak was reported to Baltimore County Health Department and provided surveyor email entries of discussion of flu outbreak. Staff #4 provided email communication with Public Health Investigator, Baltimore County Health Department between Monday, August 11, 2025, 12:30 PM to Friday, August 15, 2025, 3:16 PM regarding ?Forest Haven Flu Outbreak #2025-1157'. The emails revealed concerns discussed for the presence of pneumonia data in addition to the Flu Outbreak data within the reporting.An email dated Thursday, August 14, 2025, 9:35 AM the Public Health Investigator noted Please send copies of respiratory panel results and CXR for the residents on the outbreak. It was reported H.H. and W.W. (lines 4 and 9) had a positive CXR [chest x-ray]- please confirm the status of Legionella Urine Antigen [LUA] test. Friendly reminder, LUAs must be conducted for any resident with non-aspiration pneumonia concerns. The next entry, an email reply dated Thursday, 14, 2025 2:22 PM, sent by ADON/Infection Preventionist Staff #4 read Note there are only 3 positive cases currently in house not clear. Two residents had CXR/positive for PNA with no signs/symptoms that warrants Legionella urine antigen test as discussed with Medical Director. These residents are being monitored and to report to the MD/NP for any symptoms noted. Currently no signs/symptoms noted at this time. Of note, upon review of this entire email communication there was no discussion of the recent facility's Legionella Analytical water test results of 7/17/25. Additionally, no follow-up emails between Baltimore Health Department were offered regarding the additional pneumonia cases with onset dates after the email end date of 8/15/25.On 09/15/2025 5:01PM during a phone interview with Medical Director Staff #26, the surveyor asked why the residents in question were not tested as recommended upon request from the Public Health Investigator, Baltimore County Health Department; Staff #26 states the Legionella Urine was not done because the residents did not present with any clinical symptoms or elevated lab work consistent with that potential diagnosis. Surveyor then asked staff #26 was aware of the recent Legionella Analytical water test results of 7/17/25; staff #26 stated No. Surveyor asked Staff #26 is notified of facility testing results or concerns; staff #26 stated this would have been discussed at the Risk meetings, but I was not informed of that at the recent Risk meeting. Of note, Staff #26 could not recall the last Risk meeting exact date during the phone call. Surveyor asked Staff #26 if aware of additional pneumonia cases and stated No, I was never informed of additional pneumonia cases. Surveyor asked Staff #26 if the water test results were known when asked to complete the recommended Legionella Urine test and the increase in pneumonia cases, would a different clinical (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approach have been taken; Staff #26 stated Yes.On 09/15/2025 5:15PM during interview with Nursing Home Administrator (NHA) Staff #3, surveyor discussed concerns of increased pneumonia cases, recent Legionella Analytical testing with detected results reported on 7/17/25, and Medical Director staff #26 stating no knowledge of these findings or discussion at most recent Risk meeting. Surveyor requested date of last Risk meeting, meeting minutes, and any communication regarding water findings with the Medical Director staff #26. Staff #3 stated we did inform the Medical Director, likely at the Risk meeting.On 09/15/25 6:15PM during follow-up interview with NHA Staff #3, stated the last Risk meeting was held on 8/28/25 and confirmed Medical Director staff #26 was present; however, there were no meeting minutes from that meeting. Surveyor asked NHA Staff #3 if the Medical Director was notified of the recent water test results of 7/17/25; staff #3 stated that the Medical Director (staff #26) was informed of the water test results around the time the Public Health Investigator, Baltimore County Health Department requested the follow-up urine studies. Surveyor asked NHA Staff #3 if there any documentation to support this conversation or notification to Medical Director Staff #26; Staff #3 stated No.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review, observation, and interviews, it was determined that the facility failed to ensure resident personal and medical information was not publicly disclosed without consent. This deficient practice was evident for 3 of 3 residents reviewed (Residents #20, #45, and #65).The findings include:On 09/12/25 at 9:14 AM, review of the facility's website foresthavennursingcenter.com revealed testimonials posted with full resident names, photos of the residents, and information related to medical diagnoses for Residents #20, #45, and #65. At 9:30 AM, the surveyor brought the website up for the Director of Nursing (DON) to see and requested to review the consents from the residents to use their information on a publicly accessible website.At 10:05 AM, review of the electronic medical record showed all three residents had a Brief Interview for Mental Status (BIMS) score of 15, indicating they were cognitively intact.At 10:45 AM, the DON was unable to produce consents for Residents #45 and #65. A consent for Resident #20 was provided but was incomplete and verbally consented to by the resident's responsible party. The language used in the consent only granted permission for the resident's photo to be used on the website.At 11:01 AM, Resident #65 was interviewed and stated they were unaware their information was on the website and did not recall consenting to it.At 11:03 AM, Resident #20 was interviewed and stated they were unaware their information was on the website and did not recall consenting to it.At 11:08 AM, Resident #45 was interviewed and was unaware their information was being used on the website and did not recall consenting to it.At 11:59 AM, all three residents were asked if they were agreeable to having their information posted. Residents #45 and #65 stated they were not ok with it and wished for the information to be taken down. Resident #20 stated they had no issue with it.At 2:09 PM, an interview was conducted with the Nursing Home Administrator (NHA), who stated they were unaware of the website and would follow up after the surveyor expressed concerns.On 09/15/25 at 11:15 AM, an interview was conducted with the NHA, who remained unclear on where to locate the information and was provided the website address. No consents were produced at that time, and the NHA was still unable to identify who was managing the website. At 1:45PM, the information was noted to be taken down from the website.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 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 review of the facility's Facility Reported Incidents and interviews, it was determined that the facility failed to timely report an allegation of abuse (Resident #54). This was evident for 1 out of 7 residents reviewed for abuse during the survey. The findings include: Surveyor's review of the medical record of Resident #54 on 9/8/2025 at 1:45PM revealed the following allegation of abuse made by Resident #54 was documented by Physician #39 on 6/18/25 at 12:45PM: Patient seen today for monthly evaluation, reports two females verbally abused him/her stating shut the f*** up, reports s/he wants to go home, states s/he feels safe here but wants to go home. On 9/8/2025 at 2:07PM the surveyor conducted an interview of the facility's Administrator regarding the allegation documented in the 6/18/25 progress note, and inquired to them as to if the facility had a self-report for the documented verbal abuse allegation, to which the Administrator replied: Let me check on this. On 9/8/25 at 2:19PM the surveyor conducted an interview with Social Services Assistant Director (SSAD) #2 who confirmed with surveyors that Resident #54 had previously reported an allegation of abuse which included verbal abuse. During the interview, SSAD #2 stated regarding the Resident's allegation: It was definitely reported to the Administrator. On 9/9/2025 at 9:18AM the surveyor conducted an interview of the Administrator as to why the allegation of abuse was not timely reported to the Office of Health Care Quality until after surveyor intervention. The Administrator reported to the surveyor: Because administration didn't know about it. During the interview the Administrator reported to surveyors that Physician #39 did not them know about the allegation as they are the abuse coordinator. After surveyor intervention, the Administrator informed surveyors that because the allegation was not reported, they had instituted education in agreement with the facility's medical director for physicians and practitioners to be educated on reporting directly to the abuse coordinator, that was she can streamline and ensure communication reaches her to be reported. On 9/9/2025 at 9:18AM the surveyor shared the concern for the allegation of abuse from 6/18/25 not having been timely reported to the Office of Health Care Quality. At this time, the Administrator acknowledged and confirmed understanding of the surveyor's concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview with staff, it was determined that the facility failed to provide the written notification of transfer to the resident representative, provide written notification of the facility's bed hold policy upon transfer to the hospital to the resident representative, and ensure the local ombudsman was notified of a facility-initiated transfer to the hospital. This was evident for 1 (Resident #15) out of 4 residents reviewed for hospitalization during the annual survey.The findings include:Bed Hold is holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.On 9/5/2025 at 9:24AM, during a review of Resident #15's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on 6/23/2025 and 7/28/2025. On 9/8/2025 at 10:45AM, a review of Resident #15's electronic and paper medical record failed to reveal documentation to verify Resident #15's resident representative had been provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 6/23/2025 and 7/28/2025. There was also no documentation that the ombudsman was informed of the resident's hospital transfer on 6/25/2025 and 7/28/2025.On 9/8/2025 at 12:02PM, during a review of Resident #15's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on 9/5/2025. Further review, including the paper medical record, failed to reveal documentation to verify Resident #15's resident representative had been provided with written notification of the transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 9/5/2025. There was also no documentation that the Ombudsman was informed of the resident's hospital transfer on 9/5/2025.On 9/8/2025 at 2:28PM, the Surveyor conducted an interview with Social Services Director #1 and Social Services Assistant Director #2. During the interview, the Surveyor discovered that the Bed Hold Policy form and the Notice of Discharge or Transfer form are filled out by the social work department. The documents would then be sent to some resident representatives via email with the documents attached, and other resident representatives via certified mail. The Surveyor was informed that the social services department is responsible for informing the Ombudsman of the facility's transfers and discharges via email every month. A copy of all documents should be maintained in the residents' medical record. The Surveyor expressed the concern that there was no documentation to verify that Resident #15's resident representative was provided with written notification of the residents transfer to the hospital and the facility's bed hold policy upon transfer to the hospital on 6/23/2025, 7/28/2025, and 9/5/2025. There was also no documentation that the Ombudsman was notified of the resident's transfer to the hospital on 6/23/2025 and 7/28/2025. The Surveyor requested documentation.On 9/9/2025 at 11:10AM, during an interview with Social Service Director #1, the Surveyor was informed that as of 9/8/2025 the nursing staff would now complete the Bed Hold Policy form and Notice of Discharge or Transfer form at the time of transfer to the hospital and give a copy to the social service department. The social service department would then send the notification to the resident representative via email or certified mail. The Ombudsman would be notified of a resident transfer via email.Social Service Director #1 was unable to provide documentation that Resident #15's resident representative was emailed or sent a copy of the bed hold policy or transfer notification for the hospital transfers on 6/23/2025 and 7/28/2025. The Surveyor was provided with a copy of the email receipt to the Ombudsman for notification of all transfers and discharges, including Resident #15, for the months of June 2025 and July 2025. Social Service Director #1 stated that she was unaware the resident was out of the building to the hospital on 9/5/2025 and would complete a Notice of Discharge or Transfer form and Bed Hold Policy form and email a copy to the resident representative and the Ombudsman On 9/10/2025 at 8:00AM, the Surveyor reviewed a copy of Resident #15's Bed Hold Policy form and Notice of Discharge or Transfer form completed 9/9/2025 for the transfer to the hospital on 9/5/2025 and the email receipt to the resident representative and the Ombudsman on 9/9/2025 at 4:16PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 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 record reviews and interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and including the right to refuse treatment. This was evident for 1 (#1) resident out of 3 residents investigated for complaints during the facility's annual survey.The findings include:On 09/12/2025 11:00 AM during record review of Resident #1, it revealed the face and beard were being shaved against the family/POA preferences for resident; this occurred on more than one occasion. Resident #1 was admitted on [DATE]. Resident record review of Care Plan dated 05/28/25 revealed interventions for ADLs Functional Status/Rehabilitation Potential, started 11/20/2023, which (Resident #1) requires assistance with ADL's R/T cognitive deficit; and Cognitive Loss / Dementia, started 12/06/2023, which stated (Resident #1) is unable to make daily decisions without cues/supervision R/T diagnosis of dementia.A progress note, dated 05/03/2025 11:33 AM revealed Received resident Alert and responsive, ADL care provided as indicated, Family request LOA, when resident daughter came to pick up resident, resident is dress nice and clean, and shaved by Aid, daughter states that her mother do not want resident to be shaved by staff, updates 24 hrs report for IDT [interdisciplinary team] follow, resident left in a stable condition with no issue noted.On 09/15/2025 2:04 PM interview with Resident #1, Daughter at bedside, and wife/POA via daughter's cellphone. Surveyor observed various signage posted on resident closet, dated November 2024, with request not to shave resident and other resident preferences. Surveyor asked could family recall the initial concern when Resident #1 was shaved; daughter stated, the time was around June 2024. Family asked was the resident preferences discussed at Care Plan meetings in the past; wife/POA stated, yes, multiple times at various meetings.On 09/15/2025 6:30 PM during exit interview NHA Staff #3 notified of family concerns of repeated shaving against resident and family preferences, and Care Plan 05/28/25 not updated with resident-specific preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview with staff, it was determined that the facility failed to facilitate timely care plan meetings after a resident's quarterly assessment. This was evident for 1 (Resident #14) out of 4 residents reviewed for care planning during the annual survey.The findings include:A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility.The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs.Interdisciplinary team (IDT) is a team of medical professionals that provide specific patient centered care to the residents within a facility. On 9/8/2025 at 2:00PM, the Surveyor conducted an interview with Social Services Director #1. The Surveyor was informed that care conference (care plan) meetings are held at admission, quarterly (every 90 days), for a significant change, or as requested by the resident or resident representative. Care conference meetings are usually held during the timeframe of the MDS assessment, and the interdisciplinary team participate in the meetings.On 09/11/2025 at11:16AM, during a review of Resident #14's electronic medical record, the Surveyor discovered that the last care conference was 5/15/2025 and the next care conference was due on 8/27/2025. Further review revealed a quarterly MDS assessment completed 8/5/2025. An additional review of the resident's medical record failed to reveal documentation of a care conference meeting during the timeframe of the quarterly MDS assessment on 8/5/2025. During an interview with Social Services Director #1 on 9/12/2025 at 2:12PM, the Surveyor expressed the concern that the last care conference meeting was 5/15/2025, greater than 90 days, and there was no documentation to verify Resident #14 had a care conference meeting during the timeframe of the quarterly MDS assessment on 8/5/2025. Social Services Director #1 confirmed the Surveyor's findings. The Surveyor requested any evidence that a care conference meeting had taken place for Resident #14 since the last meeting 5/15/2025.As of the survey team exit on 9/15/2025 at approximately 6:30PM, no documentation of Resident #14's care conference meeting since 5/15/2025 had been provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews with staff, it was determined that the facility failed to complete residents Pre-admission Screening and Resident Review (PASRR) forms according to professional standards of practice. This was evident for 1 (Resident #2) out of 6 resident PASRR's reviewed during the annual survey.The findings include:The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders(MD) or intellectual disabilities(ID) and related conditions. This initial pre-screening is referred to as PASARR Level I, and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility.PASARR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD, ID or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs.On 9/8/2025 at 8:13AM, during a review of Resident #2's electronic medical record, the Surveyor discovered that the resident had diagnoses of, but not limited to, bipolar disorder, dementia, depression, and post-traumatic stress disorder (PTSD). Further review revealed physician's note dated 8/31/2023 which stated that the resident had multiple prior inpatient mental health hospitalizations, including 9/2022 and a placement at a Geri psych facility for stabilization prior to admission to the facility on 8/29/2023.On 9/8/2025 at 8:30AM, additional review of Resident #2's electronic medical record revealed a PASRR form dated 8/29/2023 and was completed by Social Service Assistant #2 upon admission to the facility. Section C #3 asks, In the past 2 years, has the individual had psychiatric treatment more intensive than outpatient care more than once (e.g.,partial hospitalization) or inpatient hospitalization, and the Social Service Assistant #2 answered No. However, the resident had been hospitalized for psychiatric treatment in 9/2022 and a placement at a Geri psych facility for stabilization prior to admission to the facility on 8/29/2023. Additionally, Social Service Assistant #2 failed to answer the follow up question to Section C Is the individual considered to have a serious mental illness? Social Service Assistant #2 proceeded to complete Section D with all No responses which indicated that the resident must be referred to Adult Evaluation & Review Services (AERS) for a Level II evaluation. Social Service Assistant #2 failed to follow up with the local AERS office.During an interview conducted with Social Service Director #1 on 9/9/2025 at 10:30AM, the Surveyor informed her of multiple concerns with Resident #2's PASRR completed on 8/29/2023. The Surveyor requested documentation to verify contact with AERS after completion of the PASRR. Social Service Director #2 asked to review Resident #2's PASRR and she would get back to this Surveyor.On 9/9/2025 at 11:10AM during an interview conducted with Social Service Director #1, she confirmed the Surveyor's findings and acknowledged that the PASRR was filled out incorrectly and AERS was not notified of the positive PASRR Level I.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review it was determined the facility failed: 1) to ensure Resident (#117) was provided assistance necessary for an activity of daily living necessary to maintain proper nutrition. This was evident during a random observation; and 2) ensure that a resident who was unable to carry out activities of daily living receives the necessary services to maintain good personal hygiene. This was evident for 1 (#114) resident out of 8 residents investigated during the survey. The findings include: 1. On 9/15/25 at 1:05PM the surveyor observed Resident #117 in the hallway sitting in their wheelchair at an overbed tray table with their lunch situated on it, with their face down to their plate licking carrots with their tongue off of their plate to get them into their mouth to eat them. Resident #117 was subsequently observed with their face down to their pudding container licking the pudding out of the container to eat it. No staff were observed to be assisting or providing supervision for the resident during this time. The surveyor went to find staff and observed Geriatric Nursing Assistant (GNA) # 37 passing a tray of food into a resident room. The surveyor conducted an interview and shared concerns with GNA #37 who reported to the surveyor that they supervise Resident #117 and reported that the resident could feed themself if they have the utensil placed in their hand. After surveyor intervention, GNA #37 was then observed walking over to the resident and then placed the utensil into Resident #117's hand, and then Resident #117 began to be able to feed themself from their plate and eat their meal using the utensil. At this time, the surveyor shared their concern additionally with Dietary Director #5 who acknowledged understanding of the surveyor's concern. On 9/15/2025 at 1:13PM the surveyor shared concerns with the facility Administrator who confirmed understanding of the concern. Review of Resident #117's care plan by the surveyor on 9/15/25 at 3:30PM revealed the following information was present: (Resident #117) requires assist with ADL care and eating: assist and continue to assess periodically for changes in cognition; adjust approaches to offer more assistance as needed. Review of Resident #117's medical record by the surveyor on 9/15/25 at 3:30PM revealed the following active medical order dated as beginning on 11/4/2024: Eating with assist of 1. 2. On 09/04/2025 at 11:30 AM during initial observation and interviews, Resident #114 was observed in bed and shared with surveyor of never being allowed to shower and that staff always give a bed bath. Surveyor asked Resident #114 when they ask for a shower, what happens; resident stated they are told, there is no shower chair large enough and the bathing area is too small. Surveyor asked Resident #114 have you ever been taken to the shower, Resident #114 states no, I am only bathed in the bed and often the sink water is cold or not warm enough. On 09/09/2025 2:49 PM during record review it revealed on the Matrix POC (Point of Care) for the period of 8/10/25-9/9/25, only complete or partial bed baths are noted as being completed or offered. During this same time only one refusal of a bed bath was documented. The record review of the Care Plan entry for ADLs, revealed it was initiated on 8/25/19 and indicates no preference between bath and shower; no changes or updates to this non-preference or desire to shower were documented during subsequent reviews of the Care Plan for ADLs. Additionally, the record review of Shower (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schedule for Resident #114, indicates a Monday and Thursday shower days. On 09/09/2025 2:54 PM during observation and interviews with GNA staff #25 and LPN staff #27, surveyor shared Resident #114 concerns of request to take a shower and repeatedly told there was no shower chair to fit resident and bathroom area was too small. Surveyor asked if was there a Bariatric chair for resident to be showered; LPN staff #25 stated yes. Surveyor asked if it had been attempted or offered for Resident #114, specifically on their assigned Monday and Thursday shower schedule days; GNA staff #25 stated no, that resident is always bathed in bed and never offered or taken for a shower. Surveyor asked LPN staff #27 has Resident #114 been offered to shower; stated that resident has history of refusing showers previously in the past when they were a resident on Unit 3. Surveyor asked LPN staff #27, how long has Resident #114 been on the current unit 2, LPN staff #114 stated a few months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and staff interviews, the facility failed to maintain an environment that is free from risks of accident hazards. This was evident for 1 (Resident #110) out of 6 residents reviewed during the survey. On 9/04/25 at 8:34 AM, during observation rounds, the surveyor observed Resident #110's toilet leaking water from the base. There was a large puddle of water on the bathroom floor surrounding the toilet. Also, the bathroom floor was slippery when walking on it. On 9/04/25 at 10:10 AM, the Director of Nursing staff #13 was interviewed. During the interview, the surveyor made staff #13 aware that Resident #110's toilet was leaking water from the base, and that there was a large puddle of water on the floor surrounding the toilet. Staff #13 mentioned that she would have maintenance repair Resident #110's toilet, and the puddle of water mopped from the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, record review, and interview with staff, it was determined that the facility failed to ensure that residents were properly assessed for the safe use of bedrails, failed to obtain consent from the resident or resident representative prior to use of bedrails, and failed to complete a device assessment for the use of bedrails. This was evident for 2 (Resident #15 and # 65) out of 8 residents reviewed for accidents during the survey.The findings include: Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident's Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails. 1. On 9/4/2025 at 8:15AM, during a tour of Station 4, the Surveyor observed Resident #15 in his/her room sleeping. The head of the bed was raised about 30 degrees and there were quarter side rails raised at the top of the bed on both sides. The resident was observed sleeping with his/her head leaning on the right-side bedrail. On 9/4/2025 at 11:21AM, during an interview with Resident #15, the Surveyor observed Resident #15 laying in bed, with the head of the bed elevated about 30 degrees and quarter bedrails raised at the top of the bed on both sides. The resident was leaning to the right side with his/her head and shoulder resting on the right-side bedrail. On 9/8/2025 at 11:30AM, a review of Resident #15's electronic medical record revealed an active physician's order dated 2/25/2025 for the resident to have quarter rails to bed for turning and positioning every shift, first, second, and third. A review revealed treatment administration records for February 2025 through September 2025 where staff documented that quarter rails were in place. Resident #15 was care planned for use of bedrails. Further review of the medical record failed to reveal a bedrail assessment, resident or resident representative consent for the use of bedrails, and a device assessment for quarter bedrails. On 9/8/2025 at 11:42AM, during an interview conducted with the Director of Nursing (DON), the Surveyor was informed that the facility uses quarter bedrails as enablers for the residents' bed mobility. The DON stated that the facility was not completing the bedrail assessments for any resident who utilized bedrails for mobility and would be initiating bedrail assessments that day. On 9/8/2025 at 12:30PM, the DON reviewed the Siderail Review and Consent form with the Surveyors. The form would be completed quarterly to assess residents for functional need and risk potential and ensure there is a physician's order and consent from the resident or resident representative for the use of bedrails. 2. On 09/04/2025 at 1:57 PM, the surveyor observed Resident #65 lying in bed with bedrails raised on the upper sides of the bed. The resident stated the bedrails were in place to assist with bed mobility. On 09/08/2025 at 11:42 AM, the Director of Nursing (DON) was interviewed and stated that the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility had not completed bedrail assessments but would begin doing so. On 09/08/2025 at 12:40 PM, the DON presented a completed bedrail assessment for Resident #65 that was created on 09/08/2025 at 11:52 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure medications were administered in accordance with physician orders for 2 of 26 opportunities reviewed. This deficient practice resulted in residents receiving medications contrary to physician orders and a medication error rate of 7.69%.The findings include:On 09/09/25 at 8:53AM, during the morning medication pass, Resident #21 was administered Topamax in a crushed form by Staff #14. During review of the resident's electronic medical record at 9:40AM it was revealed that the physician's order read for headache no crush, indicating the medication was to be given whole and was not to be crushed.On 09/10/25 at 8:22AM, during the morning medication pass, Resident #128 was administered Ferrous Sulfate 325 mg without food. Review of the physician's order indicated the medication was to be given with meals. Staff #15 was asked about the resident being given the medication without food and they stated the food trays were on their way. The surveyor observed that the resident was not served until 8:52AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, it was determined that the facility failed to ensure medications and resident information were secured to prevent unauthorized access. This deficient practice was evident for 1 of 6 medication carts observed during the facility's recertification survey.The findings include:On September 4, 2025, at 7:42 AM, during the initial tour of the facility, surveyors observed an unlocked medication cart unattended in the hallway. The drawers of the cart were able to be opened by the surveyors and revealed medications as well as resident information with protected health information (PHI). No staff were present in the area at the time of the observation. At 7:46 AM, after two surveyors had walked the length of the unit in an attempt to locate a staff member, Staff #25 was located and alerted to the situation. The nurse for the unit was sent over to ensure the cart was secured. The Nursing Home Administrator was made aware of the findings at 12:17pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure a resident who requires dental services on a routine basis received necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #15) reviewed for dental services during the survey.The findings include:On 9/4/2025 at 11:20AM, the Surveyor observed Resident #15 in bed, with the head of the bed raised about 30 degrees. As the resident spoke to the Surveyor, the Surveyor observed a brownish yellow discoloration of their own natural teeth. The resident was unable to state the last time they were seen by a dentist.On 9/8/2025 at 1:33PM, during a review of Resident #15's electronic medical record, the Surveyor discovered an active physician's order dated 7/11/2025 for a Consult: Podiatry, Ophthalmology, Dental as needed. Further review failed to reveal the last time the resident was seen by the dentist.On 9/10/2025 at 8:14AM, the Surveyor conducted an interview with Social Service Director #1. During the interview the Surveyor was informed that the social service department is responsible for scheduling dental appointments for the residents. The physicians or nursing staff would let them know if the resident or resident representative would like to see the dentist or if they need a dental consult for a particular concern, whether routine or emergent. If routine, the social service department would contact the representative from [dental group] to see if the resident was able to be seen; if so, have the resident placed on the list for the next visit. The representative would email the facility each month with the residents to be seen during that visit. If there were appointments available, the facility can add residents to the list prior to the dentist coming in. The [dental group] also visits residents on a regular schedule for preventative maintenance. If there is an emergent need, the [dental group] can add the resident to the next visit, reschedule a resident's routine visit to see the other resident, or the facility can make an appointment for an outpatient dental visit. If a resident's visit needs to be rescheduled, they should be seen on the next monthly visit. The Surveyor requested documentation of Resident #15's last dental visit.On 9/10/2025 at 2:00PM, a review of Resident #15's [dental group] note revealed that the resident was last seen by the dentist on 7/2/2024. The resident had numerous missing teeth, retained roots, and crowns; heavy soft plaque/food debris buildup and a high risk for dental caries. Recommended treatment included an annual exam, prophylactic exam at 6 months, and fluoride varnish. The next periodic oral exam should have been scheduled for 1/2/2025 and the next annual exam for 7/2/2025. The Surveyor expressed the concern that Resident #15 did not receive required routine dental services in a timely manner. Social Service Director #1 confirmed that Resident's #15's last dental exam was 7/2/2024 and that the resident did not see the [dental group] on 1/2/2025 and 7/2/2025 as recommended for preventative maintenance. Social Service Director stated that the [dental group] representative said they were backed up with routine services provided to the facility. Social Service director was unable to say why the resident's missed appointments were not followed up with by facility staff or why the resident was not seen by any dentist in the following months on next available appointment. However, Social Service Director #1 was able to schedule the resident's next dental appointment during the next [dental group] visit in October 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interview, it was determined that the facility failed to ensure the residents' right to make personal dietary choices. This was evident for 1 (#112) resident out of 8 residents investigated during the survey.The findings include:On 09/04/2025 11:08 AM during observations and interviews Resident #112 discussed with surveyor of never knowing what was coming up on the food tray at any meal. Surveyor asked resident if they have the monthly menu or alternative options; Resident #112 stated No. Of note, Resident #112 has history of Multiple Sclerosis, non-ambulatory and mostly dependent. No menu or alternative choices were observed available at resident bedside or posted on their poster board. Surveyor asked Resident #112, if meal alternatives were requested and provided when the resident requested and Resident #112 stated I used to, but I don't ask often anymore, I just accept what they give me.On 09/05/2025 11:00 AM during follow-up observation and interviews at Resident #112 bedside with LPN Staff #27 present at bedside. Surveyor notified staff of resident concerns regarding no menus and unaware of what will come on the meal trays. Surveyor asked LPN Staff #27 if any menus were provided to the residents or available on the unit for staff to inform resident of daily menu items; to which they stated No.On 09/11/2025 11:27 AM during interview and unit observations with Dietary Director Staff #5 surveyor discussed concerns regarding menu availability for non-ambulatory residents. Staff #5 states staff should have a copy available at nurse's station or have made their own copy of the Always Available list, and menus are posted on the units in glass display box. Staff #5 further shared that the Activities Director (Staff #30) is provided the menu and post them in the display glass box. Surveyor asked how the non-ambulatory residents get the menu and always available list; Staff #5 states I assume most of them ask the GNAs or someone what's coming up.The observations accompanied by Staff #5 revealed poster boards on 2nd floor in front of elevator, shared by Stations 2B & 4 was empty; walls on 2B empty due to painting and poster boards observed on the floor, rear-facing at nurse's station. On the 1st floor in front of elevator, shared by Stations 3, 2A, and Bird Room-Common area, only 3 of 4 pages of the Spring/Summer 2025 menu were present; and lastly on Station 1, just beyond the secure doors on the left the Poster Board, there was a single menu dated as Spring/Summer 2023 Week 5.On 09/11/2025 2:55 PM during interview with Activities Director Staff #30 it revealed that the quarterly menu is received from the Dietary Director (Staff #5) and it is read daily to residents during Morning Devotion or Afternoon sessions in the common Dining Room on the 2nd Floor. Surveyor asked what about residents who are unable to get to the Dining Room; Staff #30 states menus can be provided if the resident request them and menus are posted throughout unit when posted by the Dietary Director (Staff #5). Surveyor asked if they ever update the display glass box, Staff #30 stated only the monthly calendar of events, staffing events, or birthdays, I do not post or update the menus.On 09/12/2025 1:30 PM during follow-up observations and interview with Resident #112 at bedside, current Spring/Summer 2025 menu and Alternative Choices lists were observed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review it was determined the facility failed to ensure the accuracy of medical records for a resident. This was evident for 1 (#71) out of 14 residents reviewed for advanced directives during the facility's recertification survey. The findings include:On 9/4/25 at 12:50PM the surveyor reviewed the medical record of Resident #71 which revealed the following information: 1.) 2 certifications of incapacity, 2.) a guardianship order, 3.) 2 Maryland orders for life sustaining treatment (MOLST) in which neither was voided, with one MOLST form documented as being certified by the resident on 6/7/2025, and the other MOLST form documented as being certified by the resident's guardian on 3/16/2023. The second page of one of the MOLST forms dated 6/7/2025 was observed to be incomplete without selections having been made for sections 2 through 9 of the form. Both MOLST forms were observed existing with the medical record simultaneously in the same sleeve of the hard chart. On 9/4/25 at 1:01PM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #9 and shared concerns with them, at which time LPN #9 reported to the surveyor that Unit Manager #6 was unavailable, however, they acknowledged and confirmed understanding of the concerns and stated the following to the surveyor: I understand, I will address it, thank you. On 9/4/25 at 1:23PM the surveyor conducted an interview and shared concerns with Social Services Director #1 who stated the following information regarding their process for voiding of a MOLST: I leave the MOLST on the chart for the physician to void, It's waiting for the physician to void it, that 2025 MOLST was from the hospital, it's not from us, but the 2023 one is the right one that should be in effect. At this time, the surveyor shared the concern for more than one MOLST form simultaneously in resident charts, to which Social Services Director #1 replied: I just finished an audit of the charts but I didn't see that one. At this time, Social Services Director #1 acknowledged and confirmed understanding of the concern and stated s/he was going to get the MOLST to have the physician void it. After surveyor intervention on 9/4/2025 at 1:28PM, the surveyor observed Social Services Director #1 approach the physician to void the second MOLST form, which they did, and then showed to the surveyor. On 9/8/2025 at 11:42AM the surveyor conducted an interview with the facility's Director of Nursing (DON) who reported that the social worker immediately reviews the documents upon readmission after a hospital stay and that the facility will go by the most recent MOLST form and referred this surveyor to inquire to the Social Services Director as to how that process is completed. At this time, the surveyor shared their concern with the DON for the process in which the Social Services Director had previously communicated to surveyors and shared the concern with them, at which time the DON acknowledged understanding of the surveyor's concern. The DON confirmed with surveyors that nursing staff refer to the hard chart MOLST form to determine a resident's code status in the event of an emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview with staff, it was determined that facility failed to ensure regular inspections of all bedrails being used by residents. This was evident for 2 (Resident #15 and #65) out of 8 residents reviewed for accidents during the survey.The findings include: Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. Assuring the correct use of an installed bed rail and maintenance of bed rails is an essential component in reducing the risk of injury. Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. 1. On 9/4/2025 at 8:15AM, during a tour of Station 4, the Surveyor observed Resident #15 in his/her room sleeping. The head of the bed was raised about 30 degrees and there were quarter bedrails raised at the top of the bed on both sides. The resident was observed sleeping with his/her head leaning on the right-side bedrail. On 9/4/2025 at 11:21AM, during an interview with Resident #15, the Surveyor observed Resident #15 lying in bed, with the head of the bed elevated about 30 degrees and quarter bedrails raised at the top of the bed on both sides. The resident was leaning to the right side with his/her head and shoulder resting on the right-side bedrail. On 9/8/2025 at 11:30AM, a review of Resident #15's electronic medical record revealed a physician's order dated 2/25/2025 for the resident to have quarter rails to bed for turning and positioning every shift, first, second, and third. A review revealed treatment administration records for February 2025 through September 2025 where staff documented that quarter rails were in place. Further review of the medical record failed to reveal documentation of any device assessment to ensure quarter bedrails were secure, properly installed and maintained, and limited entrapment risk. On 9/8/2025 at 11:42AM, during an interview conducted with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #15 did not have ongoing bedrail assessments and evaluations of risks associated with the use of bedrails. The Surveyor was informed that the facility uses quarter bedrails as enablers for the residents' bed mobility. The DON stated that the facility had not been completing the bedrail assessments for any resident who utilized bedrails for mobility and would be initiating bedrail assessments that day. During environmental rounds and an interview with the Director of Maintenance on 9/15/2025 at 10:05AM, a Surveyor was informed that they do not check the beds for bed safety. 2. On 09/04/2025 at 1:57 PM, the surveyor observed Resident #65 lying in bed with bedrails raised on the upper sides of the bed. The resident stated the bedrails were in place to assist with bed mobility. On 09/08/2025 at 11:42 AM, the Director of Nursing (DON) was interviewed and stated that the facility had not completed any bedrail assessments but would begin doing so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/08/2025 at 12:40 PM, the DON presented a completed bedrail assessment for Resident #65. Review of the assessment revealed it was created on 09/08/2025 at 11:52 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to have multiple-resident bedrooms that measure 80 square feet per resident. This was evident for 4 resident rooms (Room # 1, #5, #6 and #9) observed during the survey.The findings include: On 9/4/25 at 8:19 AM, the Nursing Home Administrator staff #3 and Director of Nursing staff #13 were interviewed. During the interview, staff #3 and #13 were asked if the facility had a waiver related to room sizes. Staff #3 stated that the facility did not have a waiver related to room sizes. On 9/11/25 at 10:03 AM, the surveyor reviewed the facility's CMS-2567 from the last recertification survey that was conducted on 8/2/2022. Review of the CMS-2567 revealed that facility was cited for having -multiple-resident bedrooms that measure less than 80 square feet per resident. On 9/4/25 at 2:37 AM, staff #3 was interviewed. During the interview, the surveyor asked staff #3 if room [ROOM NUMBER], 5, 6 and 9 were modified to ensure that multiple-resident bedrooms measure at least 80 square feet per resident. Staff #3 stated that the facility had not made any modifications to room #s 1, 5, 6 and 9. On 9/15/25 at 2:43 PM, observation rounds were conducted with Maintenance Director staff # 18. During the observation rounds, the following room measurements were obtained: 1. room [ROOM NUMBER] was measured to be 283 square feet, for four residents' beds which indicates 70.75 square feet of space per bed/resident. 2. room [ROOM NUMBER] was measured to be 221 square feet, for three residents' beds which indicates 73.66 square feet of space per bed/resident. 3. room [ROOM NUMBER] was measured to be 214 square feet, for three residents' beds which indicates 71.33 square feet of space per bed/resident. 4. room [ROOM NUMBER] was measured to be 216 square feet, for three residents' beds which indicates 72.33 square feet of space per bed/resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to ensure that resident rooms are equipped to provide visual privacy for each resident. This was evident for 2 resident rooms (Room # 1 and 8) observed during the survey.On 9/15/25 at 9:43 AM, during observation rounds with the Nursing Home Administrator staff #3 and the Maintenance Director staff # 18, the surveyor observed a missing privacy curtain for bed A in room [ROOM NUMBER]. On 9/15/25 at 9:44 AM, staff #3 and staff # 18 were interviewed. During the interview, staff #3 agreed that there was not a privacy curtain for bed A in room [ROOM NUMBER]. On 9/15/25 at 3:05 PM, during observation rounds with staff # 18, the surveyor observed a privacy curtain that did not pull across completely for bed A in room [ROOM NUMBER]. On 9/15/25 at 3:06 PM, staff #18 was interviewed. During the interview, staff #18 agreed that the privacy curtain for bed A in room [ROOM NUMBER] did not pull across completely, and that the track for the privacy curtain was jammed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to ensure the current nurse staffing assignments and ratios for each shift was posted daily in a clear and visible place on each nursing unit. This deficient practice was evident on 7 of 8 survey days on Unit Station 2B and 6 of 8 survey days on Units 2A, 4, and 2B during the recertification survey.The findings include: 1. On 09/04/25 at 8:27 AM, during the initial tour, Station 2B surveyor observed no current nurse staffing assignments and ratios posted in a prominent place readily accessible to residents, staff, and visitors. Surveyor did observe various poster boards tucked in the Nurse station area. On 09/11/2025 at 11:45 AM during interviews with GNA Staff #28 and GNA staff 29, Surveyor regarding no poster boards and no posted nurse staffing assignments observed on the unit, the Surveyor was informed that poster boards were down due to painting. Surveyor asked how staff, residents and visitors made aware of staff assignments and GNA Staff #28 stated staffing sheets are located at the nurse's station on the back wall for their use; of note, this wall at the back wall was not visible from the main hall for residents or visitors to see. Surveyor asked how long the poster boards had been off of the walls and GNA Staff #28 and GNA Staff #29 both indicated it was early summer since the painting began and no follow-up after painting was done. On 09/15/2025 at 2:00 PM during follow-up observation on unit Station 2B, after surveyor intervention poster boards were then observed on walls with current posted nurse staffing assignments. 2. On 09/04/25 at 7:39 AM, during the initial tour, Station 3 did not have the current nurse staffing ratio posted on the dry erase board in the hallway for residents and visitors to see. 3. At 7:41 AM, Station 2A was observed without the current shift staffing; the posting was from the prior day (09/03/25). The findings were brought to the attention of the Nursing Home Administrator (NHA) at 12:17 PM the same day. 4. On 09/08/25 at 9:10 AM, Station 4 was observed without the required staffing ratio posting. On 09/09/25 at 8:46 AM, Station 4 again did not have the staffing ratio posting. On 09/10/25 at 8:39 AM, Station 4 did not have the staffing ratio posting. On 09/11/25 at 10:14 AM, Station 4 again did not have the required staffing ratio posting. 5. On 09/15/25 at 10:15 AM, Station 2B was observed without the staffing ratio posting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215252	A. Building B. Wing	09/15/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, record review, and interview with staff, it was determined that the facility failed to have the most recent survey results posted and accessible to residents, family members, and legal representatives of residents. This had the potential to affect all residents and visitors within the facility. The findings include:On 9/10/2025 at 7:25AM, the Surveyor observed the facility's Survey Binder on a console table in the reception area next to the Receptionist desk.On 9/10/2025 at 11:26AM, a review of the Survey Binder failed to reveal the results of the most recent complaint survey conducted on 4/21/2025-4/25/2025 and 4/28/2025-5/1/2025, as well as the on-site revisit survey conducted on 7/31/2025, 8/1/2025, and 8/4/2025. The Survey Binder contained survey results from a complaint survey 5/30/2024 and an annual survey 8/2/2022.During an interview conducted with the Director of Nursing (DON) on 9/11/2025 at 3:10PM, the Surveyor and the DON confirmed that the most recent survey results were not in the Survey Binder. The Surveyor was informed that the DON was not aware that results from complaint or revisit surveys needed to be accessible to residents and visitors by being posted in the Survey Binder. She thought that only the annual survey results needed to be included in the Survey Binder.