STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215327	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sligo Creek Healthcare	7525 Carroll Avenue Takoma Park, MD 20912

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure medical records were provided when requested. This was found to be evident for 1 (Resident # 8) out of 1 Resident reviewed for medical records during the complaint survey.The findings include: During a review of complaint #331189 conducted on [DATE] at 9:00 AM, the complainant reported that he/she requested Resident #8's medical records on [DATE] however the facility did not fulfill the request. The complainant further reported that when he/she requested a copy of the Resident's medical records for a second time the facility requested that he/she provide a letter of administration because the Resident was now deceased . During an interview conducted on [DATE] at 9:44 AM, the medical records staff member explained that the process for requesting medical records is as follows: once he received a request, he verified if the person is authorized to receive the medical records. Once verified the person will complete a form. The form is then sent to corporate who sends the request to a legal firm who approves the request. Once approved the medical records staff member would gather the medical records and either electronically send the records or send them via mail. He stated that he kept an electronic copy of the request and medical records that were sent out. The Medical records employee returned on [DATE] at 10:36 AM, provided this surveyor with an email that confirmed that the complainant requested Resident #8's medical records on [DATE]. He further stated that he recalled that the complainant came to facility and notified the facility that the Resident had passed away a couple of weeks ago. The complainant requested medical records but was told that he/she must have a letter of Administration now that the Resident was deceased . This Surveyor expressed concern that the complainant requested the medical records prior to the Resident passing away. During an interview conducted on [DATE] at 10:40 AM, the Director of Nursing (DON) acknowledged that the complainant first requested the medical records on [DATE] prior to Resident #8 passing away, however the request for medical records was not fulfilled at the time of the request.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, it was determined that the facility failed to ensure a thorough investigation was completed for an allegation of abuse. This was found to be evident for 3 (Resident #2, & #7) out of 4 Residents investigated for abuse during the compliant survey.The findings include: During a review of the Facility Reported Incident (FRI) # 2598686 conducted on 10/20/2025 at 9:55 AM, it was discovered that Resident #2 reported that two Nursing Assistants came into his/her room to provide care and pounded on him/her and broke the phone. The facility's investigation included law enforcement notification, a statement from the resident, alleged perpetrators, other staff, and cognitively intact residents. However, the facility failed to assess the cognitively impaired residents that were assigned to the alleged perpetrators. During a review of the FRI #331192 investigation conducted on 10/20/25 at 12:59 PM, it was revealed that Registered Nurse (RN) #3 observed Resident # 11 standing beside Resident #7's bed. She stated that she observed Resident#11 hit Resident #7 on the left side of the head with an object.During a continued review of the investigation, it was discovered that the facility obtained statements from staff and notified law enforcement but failed to interview and assess residents that may have had an interaction with Resident #11. During a review of the FRI #331177 investigation conducted on 10/21/25 at 10:20 AM, it was discovered Resident #10 reported that a Geriatric Nursing Assistant (GNA) slapped him/her in the face and sat on both of their hands while the GNA provided care. A further review of the investigation revealed that law enforcement was notified, a statement was obtained from the resident, alleged perpetrator, other staff and cognitively intact residents. However, cognitively impaired residents were not assessed for abuse that were assigned to the alleged perpetrator.During an interview conducted on 10/21/25 at 10:33 AM, the Director of Nursing acknowledged that cognitively impaired residents had not been included in the investigation of abuse. She further stated that she understood the importance and would be implementing a practice that would include assessing the most vulnerable residents who were cognitively impaired when investigating abuse allegations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of facility reports it was determined that the facility failed to prevent a cognitively impaired Resident with exit seeking behaviors from exiting the facility. This was found to be evident for 1 (resident #5) out of 1 Resident reviewed for an elopement. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy Past Non-compliance.The findings include: Brief Interview for Mental Status (BIMS) is a five-item screening that assesses memory and orientation by asking patients to recall words and state the current year, month, and day. Scores from 13-15 indicate intact cognition, 8-12 suggest moderate impairment, and 0-7 point to severe impairment.During a review of the facility reported incident #2639738 conducted on 10/17/25 6:30 AM, it was discovered that Resident #5 with a BIMS of 5 and a history of exiting seeking behaviors eloped from the facility on 10/09/25. During an interview conducted on 10/17/25 at 6:45 AM, Resident #5 gave the Surveyor multiple different accounts of the day he/she eloped on 10/09/25. During an interview conducted on 10/17/25 at 7:42 AM, the Maintenance Director (MD) reported that on the day of the incident, Resident #5 was seen on the camera footage entering the first-floor nursing unit from the second-floor elevator. The Resident was seen pushing on the locked exit door by the activities room. When unable to open the door the Resident then walked into the service hallway through the unlocked double doors. The MD explained that in viewing the camera footage it was discovered that Resident #5 entered the unlocked laundry room where he/she exited the facility. The MD stated that there was an exit door in the laundry room that led directly outside. The door did not have a lock, wanderguard sensor, or an alarm at the time the Resident exited the facility. The MD reported that the laundry tech failed to lock the door behind him when he left the laundry room. He further stated that at the time of the incident the door could only be locked with a key. During a tour of the facility conducted on 10/17/25 at 8:00 AM, the MD and Surveyor observed the laundry door that now had an automatic lock. The exit door inside of the laundry room was bolted shut. During the continued tour each exit door was observed locked with a wander guard sensor and a pin pad.During an interview conducted on 10/7/25 at 8:32 AM, the Director of Nursing (DON) reported that she called Resident #5's family member on 10/09/25 about a room change and that's when she was made aware that the Resident was no longer in the facility. The DON stated that the family member notified the DON that the Resident was at the Silver Spring Metro Station (about 2.3 miles from the facility). However, several minutes later the family member called again and notified the DON that the Resident was no longer at the Silver Spring Metro station, and they were en route to the facility. The DON reported that while the family member was at the facility he/she received a call that Resident #5 had arrived in a cab to the formerly known St Elizabeths Hospital located in the Southeast District of Columbia seeking help. The DON stated that the Social Service Director, Director of Rehab, Regional Director of Clinical and herself drove to the location, assessed the Resident and returned to the facility around 4:00 PM on 10/09/25. The DON stated that after an investigation the facility determined that the Resident was last seen in the facility around 10 AM when he/she received their medication. A Wanderguard is a type of wander management system used in senior living communities and healthcare facilities to prevent residents at risk of wandering from leaving the premises unsupervised. The system uses discreet wearable bracelets for residents and can include other components like door sensors to create a protective environment. If a resident wearing a bracelet attempts to go beyond a designated area, the system triggers an alert to notify staff, who can then provide immediate assistance. During a record review conducted on 10/17/25 at 9:45 AM, it was discovered that Resident #5 was assessed as an elopement risk and a wanderguard was placed on the right ankle on 08/19/25. A care plan is a written document that outlines the specific healthcare and support needs of an individual. It serves as a roadmap for providing personalized care and ensuring that all aspects of the patient's well-being are addressed. During record review conducted on 10/17/25 at 9:55 AM, it was discovered that Resident #5 had a care plan for wandering on 08/19/25 with an intervention that stated, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.During a phone interview conducted on 10/17/25 at 10:00 AM, the Resident's family member reported that a bus driver at the Silver Spring Metro station called at 12:04 PM on 10/09/25 at the request of the Resident. The family member stated that he/she told the Resident that he/she would be there to pick him/her up. A few minutes later the bus driver called back and reported that the Resident was no longer at the bus terminal and did not know where or what direction the