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	06/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and staff interviews, it was determined the facility staff failed to provide respect and dignity to residents by failing to knock on the resident's door prior to entering the resident's room. This was evident for 1 (Resident#17) out of 1 resident observed during complaint and recertification survey process. The findings include: On 06/02/2026 at 10:18 AM during the complaint investigation, Resident #17 reported concerns that staff do not knock prior to entering the room, stating that this occurs on an ongoing basis. On 06/02/2026 at 10:39 AM the surveyor observed GNA#23 enter Resident#17's room without knocking or introducing herself prior to entry. During an interview, the GNA stated that the expectation is to knock before entering a resident's room and confirmed that she did not knock or introduce herself before entering. On 06/05/2026 at 11:46 AM the surveyor observed GNA#25 enter Resident #17's room with a Hoyer lift without knocking on the door prior to entry. During an interview, the GNA stated that the expectation is to knock before entering a resident's room and confirmed, I am sorry I did not knock before entering. On 06/05/2026 at 11:50 AM Resident #17 stated, I am glad you witnessed what I always complain about. Something needs to be done. On 06/05/2026 at 12:00 PM an interview was conducted with the Director of Nursing (DON), who stated that the expectation is for staff to knock before entering residents' rooms. The surveyor shared her observation with the DON. The DON further stated that in-service education for staff regarding this expectation is ongoing.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview with the resident and facility staff, it was determined that the facility failed to ensure clean, safe, and comfortable environment. This was evident for 2 (Resident #10 and Resident #71) of 2 residents reviewed during the annual survey. The findings include: On 06/03/2026 at 9:50 AM, the surveyor observed that in Resident #71's bathroom wall-mounted light fixture above the hand sink was flickering. The wall surfaces surrounding the hand sink were cripped, cracked and pitted. The baseboards beneath the sink were lifting, peeling, and cracked with a buildup of mold-like substance present. The surveyor also observed that the resident's nightstand was missing a lockable drawer, and the cabinet door that was detached and hanging off its hinge. An interview with Resident #71 revealed that the Maintenance Director had been notified of the damaged nightstand and repairs had been requested. On 06/03/2026 at 11:00 AM, the surveyor observed Resident #10 bathroom was missing a towel rack, with only the two mounting brackets remaining attached to the wall. During an interview, Resident #10 stated that washcloths and personal hygiene items were stored on top of a trashcan due to the lack of available storage space. However, the placement of these items on the trashcan also obstructed access to the hand sink. On 06/03/2026 at 2:30 PM, the surveyor revisited Resident #71 and Resident #10 with the Administrator and the Environmental Services (EVS) Director. The Administrator confirmed the observations and stated that repairs or replacement of the damaged bathroom fixtures, deteriorated baseboards, and damaged nightstand would be completed promptly.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on resident and staff interviews, and record review conducted during the complaint investigation, it was determined the facility failed to ensure resident grievance regarding missing personal belongings were promptly addressed and resolved. This was evident for 1 (Resident #17) of 2 residents reviewed for grievances during the complaint and recertification survey process. The findings include: On 06/02/2026 at 10:25 AM, Resident #17 reported missing clothing items, including more than two white sweatshirts, one black shirt, and one black blouse, for the past few weeks. The resident stated that the items were sent to laundry and were never returned. The resident reported informing the 3:00 PM–11:00 PM shift nurse and several GNA (Geriatric Nursing Assistant) regarding the missing clothing. On 06/04/2026 at 10:27 AM an interview was conducted with the Director of Nursing (DON) regarding the facility's process for addressing missing resident items. The DON stated that upon notification of a missing item, staff review the resident's inventory record, search the resident's room, and check the laundry area with the Laundry Manager. The DON further stated that if the item is not located, the resident is notified, a grievance form is completed by the resident, family, or resident representative (RP), and forwarded to Social Services #31 for follow-up. The DON stated that items documented on the resident's inventory sheet are replaced by the facility if not found. On 06/04/2026 at 10:15 AM interview conducted with Social Services #31 regarding the process for reporting grievances related to missing items. The SW stated that the resident or responsible party (RP) reports the missing item to the GNA or nurse. The staff member receiving the grievance completes a grievance form and places it in the SW's mailbox for follow-up. On 06/04/2026 at 10:33 AM an interview was conducted with the Social Services #31 regarding Resident #17's report of a missing item. The SW stated that Resident #17 reported a missing white sweatshirt and had previously spoken with the laundry department prior to notifying the SW of the concern. The SW further stated that the resident reported the missing item a few weeks earlier; however, the exact timeframe was unknown. On 06/04/2026 at 10:36 AM surveyor review of the grievance binder with the Social Services #31 revealed no documentation indicating that Resident #17's grievance regarding the reported missing item had been initiated, investigated, or addressed. On 06/04/2026 at 10:42 AM following surveyor intervention, the SW stated that she would follow up with Resident #17 regarding the reported grievance related to the missing item in an effort to investigate and resolve the concern. On 06/05/2026 at 11:48 AM surveyor follow-up interview with Resident #17 revealed that no staff had spoken with him/her regarding the reported missing items. Resident #17 further stated that the Business Office Manager (BOM) and the SW came to the room to discuss the appeal process and provided a denial letter; however, the resident reported that the concern regarding the missing items was not discussed or addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2026 at 12:00 PM during an interview, the Director of Nursing (DON) confirmed that the Social Services #31 was expected to follow up with Resident #17 regarding the reported missing items. The DON further stated that the facility was in the process of replacing the items; however, Resident #17 had not been informed of the plan for replacement. On 06/08/2026 at 11:19 AM following surveyor intervention, the DON reported that the facility had purchased the missing items for Resident #17 and stated that she would speak with the resident regarding the replacement of the items.

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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 medical record review and staff interviews, it was determined that the facility failed to ensure required notifications were completed during the resident transfer/discharge process. This was evident for 3 residents (Resident #4, Resident #34, and Resident #93) out of 6 total residents reviewed for transfer/discharge requirements during the complaint and recertification survey. The findings include: On 06/02/2026 12:37 PM review of Resident # 4's medical record revealed that on 3/19/2026 the Resident was transferred to the hospital and returned on 3/26/2026. On 06/03/2026 at 1:05 PM a review of Resident #4's medical records revealed no documentation indicating that the facility informed the Ombudsman of the resident's transfer to the hospital. On 06/03/2026 at 2:00 PM Social Services #31 submitted a report for March 1 through March 31, 2026. A review of the report revealed that Resident #4 was not listed on the report. On 06/04/2026 at 11:16 AM interview conducted with Social Services #31 regarding Ombudsman notification. Social Services #31 stated that reports are sent via email monthly. Review of the Ombudsman report for the month of March 2026, conducted with Social Services #31, revealed that the resident's transfer to the hospital was not communicated to the Ombudsman. Social Services #31 confirmed that the resident was not listed on the report. On 06/04/2026 at 1:30 PM, a review of Resident #34 medical record revealed a progress note dated 5/6/2026 documented by social services, stating that the facility issued a notice of discharge to Resident #34 for Tuesday May 12, 2026. On 06/05/2026 at 10:00 AM, the facility provided the requested written discharge notice for Resident #34 that was issued for 5/12/2026. It confirmed Resident #34 was given a letter signed by the Nursing Home Administrator informing the resident of the impending discharge by the facility with 6 days' notice to a Red Lion Inn with 4 nights paid for by the facility. The letter provided to Resident #34 did not include the required notice of discharge information that included reason for discharge and rights to hearing and mediation. On 06/05/2026 at 10:54 AM, an interview with the Nursing Home Administrator (NHA) revealed he was the one who wrote and signed the letter for Resident #34. The NHA stated the letter was an agreement and not a notice of discharge. He reports he verbally informed the resident of their rights and that they agreed to the 4 nights of hotel stay instead of a 30-day notice. He then stated Resident #34 changed their mind and asked for the 30-day notice which is when the facility then provided the written 30-days' notice on 6/1/26. The NHA stated he was not aware that Social Services documented the letter given to Resident #34 as a notice of discharge date in a progress note. Concerns were shared with the NHA that the facility's discharge process and policy were not followed for the letter of agreement given to the resident and that Resident#34 was not provided the required notice of discharge information that included the reason for discharge and rights to hearing and mediation. On 06/08/2026 at 8:39 AM, a review of Resident #93 medical record revealed in a nursing progress (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note dated 4/7/2026 the resident left the faciity on 4/7/2026 for approved leave of absence. The next entered progress note in Resident #93 medical record was dated 4/15/2026 and confirmed the resident was not able to be seen for wound care rounds due to being discharged home. On 06/08/2026 at 9:00 AM, an interview Social Services #31 confirmed Resident #93 left the faciity on 4/7/2026 for an approved leave of absence and did not return when the resident was scheduled to. Social Services #31 stated the facility reached out to the resident and let them know they would be discharged against medical advice (AMA) if they did not return to the facility. Social Services #31 then confirmed that the facility did not document any of the phone contacts they had with Resident #93 or any discharge progress notes in the resident's medical record. Social Services #31 also confirmed that the facility did not mail any written notice of discharge to Resident #93 or provide the required notice of discharge information that included reason for discharge and rights to hearing and mediation. On 06/08/2026 at 9:17 AM, a review of the facility's discharge policy confirmed the facility had a process for AMA discharge that included contacting the residents to inform them of their rights, notification to medical provider, discharge progress note to be written by social services or nursing, and contacting other community entities as needed for AMA discharge. On 06/08/2026 at 1:00 PM following the surveyor's intervention, Social Services #31 submitted a Hospital Tracking Portal report and emailed it to the Ombudsman on 06/08/2026 at 12:52 PM.

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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 record review, observation, and interview, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as is possible. This was evident for 1 (Resident #94) out of 1 resident reviewed for accidents during the investigation into facility reported incident #2988228.The findings include:On 06/03/2026 at approximately 7:00 AM, this surveyor conducted an interview with the Director of Nursing (DON) regarding a facility-reported incident involving Resident #94. The DON confirmed that the facility investigated and verified the allegation after reviewing security camera footage, which showed Resident #94 exiting the facility through a secured door located adjacent to the resident lounge area. The DON reported that a staff member had opened the door to allow a visitor to exit the facility, and before the door had fully closed and secured, Resident #94 was able to exit through the same door and leave the facility. The DON confirmed that this was how the resident eloped from the facility.On 06/03/2026 at approximately 8:30 AM, this surveyor conducted a dual observation with the Maintenance Director of the exit door identified as the door used by Resident #94 during the incident. During the observation, the door was found to require approximately 15 seconds to fully close and secure after being opened.On 06/03/2026 at approximately 9:30 AM, this surveyor conducted a record review of the facility's investigation related to the elopement incident involving Resident #94 that occurred on 04/18/2026. The investigation revealed that Resident #94, who had a BIMS score of 0 and diagnoses including dementia with behavioral disturbance, metabolic encephalopathy, cognitive communication deficit, and dysphagia requiring enteral feeding, was observed on 04/18/2026 sitting in the lounge area near the exit door at approximately 9:00 AM by Geriatric Nursing Assistant (GNA) #34 and again at 10:10 AM by Registered Nurse (RN) #35. The investigation further revealed that at approximately 11:00 AM on 04/18/2026, RN #35 identified that Resident #94 was no longer present in the lounge area, prompting an immediate facility-wide search. At approximately 11:10 AM, the DON notified local law enforcement that the Resident was missing. During the search, the facility was contacted by a physician from Holy Cross Hospital who reported that Resident #94 had been found in the community attempting to enter a stranger's vehicle and was subsequently transported to the hospital by ambulance. A continued review of the investigative file revealed that security camera footage confirmed Resident #94 exited the building through the secured unit door located adjacent to the lounge area. The facility determined that the door had not fully closed and secured prior to staff disengagement, allowing the Resident to exit the facility. The investigation further revealed that although Resident #94 had previously been assessed as low risk for wandering, the Resident required supervision due to impaired safety awareness and significant cognitive impairment. Documentation showed the resident had a BIMS score of 0 and diagnoses including dementia with behavioral disturbance, metabolic encephalopathy, cognitive communication deficit, and dysphagia requiring enteral feeding. The facility verified the allegation of neglect based upon the investigative findings.On 06/03/2026 at approximately 9:51 AM, this surveyor conducted a telephone interview with Resident #94's daughter. She reported receiving notification from Holy Cross Hospital that Resident #94 had been found in the community and transported to the emergency department after attempting to enter a stranger's vehicle.On 06/03/2026 at approximately 10:17 AM, this surveyor contacted the local police department, which confirmed that it received a missing resident report from the facility on 04/18/2026 at approximately 11:10 AM.Following the incident, the facility implemented corrective actions including restricting use of the exit door involved in the incident, reassessing residents for elopement risk, updating care plans and interventions, providing staff re-education regarding elopement prevention and door security protocols, and implementing ongoing monitoring through audits and QAPI oversight. Therefore, the deficient practice was corrected prior to the survey and the facility achieved substantial compliance; this citation is issued as past noncompliance.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, record review, and interviews with the residents and facility staff, it was determined that the facility failed to ensure that residents received meals consistent with their food preferences and physician's prescribed therapeutic diets. This was evident for 3 (Resident #10, Resident #38, and Resident #62) of 3 residents reviewed for dietary services. The findings include: On 06/03/2026 at 8:10 AM, the surveyor observed the meal ticket for Resident #10. The meal ticket included the resident's name, room number, date, and prescribed diet. However, the beverage selection was listed as N/A, and the Food Likes, and Food Dislikes sections were blank. At 8:30 AM, record review revealed that Resident #10 had an order dated 07/09/2025 for a low sodium, regular texture, and regular liquid consistency diet. At 9:40 AM, during an interview, Resident #10 stated that meals were not consistently served according to personal preferences. The resident reported repeatedly receiving cornflakes and two hard boiled eggs everyday for breakfast instead of the preferred raisin bran cereal. At 11:50 AM, the surveyor observed Resident #38's meal ticket, which identified the diet as Regular/CCHO. The resident was served Salisbury Steak with gravy, mash potato with gravy, and green beans. When asked about the diet order, the Food Service Director explained that CCHO stood for Controlled Carbohydrate and was intended for resident with diabetes. However, Resident #38 received the same meal and portion sizes as residents on regular diets. The surveyor asked how resident food preferences were incorporated into meal service. The Food Service Director stated that preferences were entered upon admission and could be updated through requests submitted by nursing staff. In addition, residents could request alternative menu by calling down to the kitchen or by asking a staff member at any time of the day. At 12:15 PM, the surveyor reviewed Resident #62's meal ticket, which identified a regular diet, 2mg of sodium, and shellfish allergy. Staff #10 prepared a grilled cheese sandwich with white cheese, which was listed as a preferred item. When questioned about the meal selection, Staff #10 stated that kitchen personnel were aware of residents receiving alternate menu items such as baked chicken, white rice and steamed carrots, even when those items were not clearly identified on the meal ticket. At 12:36 PM, Resident #62 approached the Food Service Director and asked what was being served for lunch. After being informed that a grilled cheese sandwich had been prepared, the resident became upset and stated that the kitchen frequently served food that had not been requested, particularly food made with white cheese. The resident further stated that other residents were receiving Salisbury steak or baked chicken and did not understand why an alternate meal had been provided. At 1:30 PM, record review revealed that Resident #38 dietary order had last been updated on 01/28/2025 and Resident #62 dietary order had last been updated on 01/29/2024. Neither resident's documented food preferences had been updated in the care plans since those dates. At 2:00 PM, the surveyor informed the Administrator that the meal tickets were difficult to interpret (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because alternative menu selections and resident food preferences were not clearly identified. The Administrator was also informed that multiple residents had voiced concerns regarding meal service and food selections. At 3:30 PM, during the preliminary exit interview, the Regional Clinical Director, Director of Nursing, Nursing Home Administrator, Maintenance Director, Environmental Services Director, and the Food Service Director were notified of the meal ticket discrepancies. Based on observation, record review, and interviews with the residents and facility staff, it was determined that the facility failed to ensure that residents received meals consistent with their food preferences and physician's prescribed therapeutic diets. This was event for 3 (Resident #10, Resident #38, and Resident #62) of 3 residents reviewed for dietary services.