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	02/20/2025

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 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. 16218 Based on medical record review, observation and interview it was determined that the facility failed to maintain a resident's dignity by failure to ensure a urinary catheter bag was maintained with a privacy cover. This was found to be evident during a random observation of Resident #49. The findings include: Review of Resident #49's medical record revealed the resident has had a urinary catheter for at least the past six months. On 2/14/25 at 9:58 AM Resident #49 was observed sitting in a wheelchair in the activity room while music was playing. Surveyor noted a partially filled urinary catheter drainage bag hanging on the side of the wheelchair. The catheter bag did not have a privacy cover. On 2/14/25 at 10:03 AM surveyor requested the nurse (Staff #10) observe Resident #49's catheter bag. On 2/14/25 at 10:06 AM nurse #10 was observed obtaining a privacy bag. Follow up observation of the resident at approximately 10:20 AM revealed Resident # 49's urinary drainage bag was now in a privacy bag. On 2/14/25 at 11:47 AM surveyor reviewed the dignity concern with the Assistant Director of Nursing (ADON) related to the failure to have a privacy bag covering the resident's urinary drainage bag. During an interview on 2/19/25 at approximately 2:20 PM, the Director of Nursing (DON) indicated she was aware of this concern and had already spoken with the staff involved. The DON went on to report that prior to the surveyor observation, the nurse had instructed the GNA (geriatric nursing assistant) to apply a privacy bag but this had not occurred.

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
	215327	A. Building B. Wing	02/20/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48470 Based on record reviews and interviews, it was determined that the facility failed to ensure that information was provided to residents to formulate an advanced directive. This was evident for 2 (Resident #1, #10) of 7 residents reviewed for advanced directives during the survey. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. A medical records review of several residents was conducted during the initial pool. The review identified residents that did not have credible evidence of an advanced directive. These residents include: a) On 2/11/25 at 9:37 AM, Resident #1 had a document in his/her hard chart titled Health Care Decision Making dated 12/19/2013. This document explained the resident's right to formulate an advanced directive with an area in the bottom that asked, does the patient have an advance directive? Which was marked as no, and another question that asked, resident/patient wants to proceed further with social services? Which was marked as yes. Resident #1's electronic health record (EHR) also indicated that the resident had an intact cognition. b) On 2/11/25 at 10:35 AM, Resident #10's EHR indicated that the resident had intact cognition and that s/he was his/her own responsible party. On 2/18/25 at 12:28 PM, the Social Services Director (SSD) was interviewed about her process with advanced directives. The SSD reported that she would ask about this upon the residents' admission, if they don't have one and determined that they have the cognitive ability to formulate one, then she would ask if they would like to make one and provide the information. The SSD also reported that advanced directives are followed up and reviewed during care plan meetings. In a subsequent interview with the SSD, Residents #1 and #10 were discussed. The SSD reviewed the residents' medical records and confirmed that neither resident had advanced directives and that there was no evidence that it was followed up on or discussed in their care plan meetings. The SSD also confirmed that these residents were their own responsible parties. On 2/19/25 at 2:43 PM, the concern was discussed with the Director of Nursing (DON) that the facility failed to ensure information was provided to the residents to formulate advanced directives. The DON verbalized understanding and acknowledged the concern.

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	02/20/2025

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 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. 45139 Based on review of pertinent documentation and interviews, it was determined that the facility failed to have a procedure in place to provide the residents with written notifications concerning resolution to grievances. This was evident for all residents' grievance forms reviewed during the survey. The findings include: On 2/18/25 at 10:30 AM a review of intake #MD00205216 revealed a concern regarding the facility's process of resolving residents' complaints and grievances. On 2/14/25 at 12:27 PM the Social Services Director (SSD Staff #13) provided the 2024 and 2025 grievance record book. On 2/14/25 review of 18 out of 18 grievance forms written between October 2024 through January 2025 failed to reveal documentation that the resident received and/or agreed to the resolution of the grievance. Further review revealed a space available for the signature and date for the Resident to sign that they were notified. Further review revealed that the Social Service Director signed in this space, or that it was left blank. On 2/14/25 at 12:08 PM The Director of Social Services (Staff #13), reported that she is the facility grievance official responsible for the resident's grievance process. She reported that she receives the grievance and forwards the grievance to the appropriate department. She reported that the resident and or the resident's representative is not issued a written decision on the grievance. On 2/18/25 at 9:00 AM the Director of Nursing (DON) confirmed that the Social Service Director #13 was signing in the space labeled for the resident, in addition the DON stated she was unaware that the resident and or resident representative should be informed in writing of the resolution of the grievance. On 2/19/25 the facility policy titled Concern or Grievances Policy was reviewed. The policy documented that the grievance official will issue a written decision on the grievance to the resident or resident representative at the conclusion of the investigation.

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	02/20/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 51900 Based on a review of resident medical records and staff interviews, it was determined that the facility failed to ensure an accurate Minimum Data Set (MDS) assessment when documenting pressure ulcers. This was evident in one (Resident #66) out of seven residents reviewed for pressure ulcers. The findings include: A review of Resident #66's medical record revealed the resident was readmitted to the facility after a more than one-week hospitalization in late December 2024. A Minimum Data Set (MDS) is a standardized assessment tool that helps to evaluate the health status of residents in long-term care facilities. The information gathered helps facilities to develop patient-centered care plans based on the residents' unique needs. The MDS assessment is a mandated requirement for all residents. On 02/12/25 at 11:40 AM, the surveyor reviewed Resident #66's MDS assessment which had an assessment reference date of 1/7/25. A review of the skin assessment section of this MDS revealed documentation that the resident had two pressure ulcers that were present upon admission: one stage two pressure ulcer (PU) and one unstageable Deep Tissue Injury (DTI). An assessment reference date is the last day of the observation period that serves as the look-back period of an MDS assessment. A Pressure Ulcer (PU) is a skin injury caused by prolonged pressure on an area of the body. Pressure ulcers are a result of restricted blood flow to tissues that results in skin breakdown, open sores, or ulcers. Deep Tissue Injury (DTI) is a type of pressure ulcer that results in damage to soft tissue beneath the skin that extends to tissues beneath the skin, even if the surface skin may appear intact. On 02/12/25 at 12:20 PM, a review of the wound specialist nurse practitioner's assessment note, dated 1/7/25, revealed documentation of a left heel pressure ulcer measuring 4.0 cm x 4.50 cm x 0.10 cm (length, width, depth) and indicated it was a DTI. This note also documented that the DTI was present on admission, however further review of the medical record failed to reveal documentation to indicate the presence of the DTI prior to this 1/7/25 assessment. On 02/12/25 at 12:45 PM, the surveyor reviewed orders for Resident #66 which stated that the resident should have skin prep applied directly to the left heel DTI and left open to air every shift for wound care from 01/08/2025 to 01/19/2025. No orders were found for treatment to the DTI prior to 1/8/25. (continued on next page)

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	02/20/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/25 at 08:43 AM, the surveyor interviewed the MDS Coordinator (Staff #5) who stated that she completes the MDS skin assessments based on what the nurses document on the computer. The surveyor notified the MDS Coordinator that no documentation was found to support that the DTI was present on admission and asked if she had any additional documentation regarding this concern. The MDS Coordinator indicated that she would follow up with nursing and get back to the surveyor. On 02/14/25 at 09:20 AM, the MDS Coordinator confirmed that the pressure ulcer was marked present on admission in error and that the treatment order for the DTI was placed after the resident's assessment. She stated that she would submit a correction for the MDS skin assessment.

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	02/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 16218 Based on observation, medical record review and interviews it was determined that the facility failed to develop comprehensive person-centered care plans for each resident and failed to provide a resident with a timely comprehensive care plan. This was found to be evident for 4 (Resident #66, #19, #2 and #352) out of 42 resident's reviewed during the survey. The findings include: 1) Review of Resident #66's Significant Change Minimum Data Set (MDS) assessment, with an assessment reference date of 1/7/25, revealed the resident had functional limitations in range of motion for upper and lower extremities (arms and legs) on both sides, and the resident was dependant on staff for activities of daily living such as bathing, dressing and moving in bed. Observation of Resident #66 on 2/11/25 at 8:52 AM, 2/13/25 at 10:15 AM and 2/18/25 at 12:22 PM revealed quarter side rails were in the up position. On 2/18/25 review of the Proper Use of Side Rails policy revealed: An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. On 2/18/25 further review of the medical record revealed a Side Rail Evaluation, dated 12/31/25, that documented the benefit of the side rail was to assist with bed mobility and that the care plan was updated. Further review of the medical record, including the orders and the current active care plan, failed to reveal documentation to address the use of the side rails. Further review of the facility's Proper Use of Side Rails policy revealed: The use of side rails as an assistive device will be addressed in the resident care plan. On 2/19/25 at 2:12 PM the Director of Nursing (DON) was interviewed in regard to the use of side rails. When asked if the facility obtains orders or addresses the use of side rails in the resident's care plan, the DON responded that they have assessments. Surveyor reviewed the concern that the assessment indicated the care plan was updated but no documentation was found in the care plan to indicate side rails were being used. 2)Resident #19 had a history of a cerebral infarction (stroke) that resulted in contracture of the muscles in the left hand. A contracture is a shortening and hardening of the muscles and tendons that may lead to deformity or rigidity of the joints. On 2/10/25 at 2:44 PM, the Rehabilitation Director (Staff #6) reported that Resident #19 had previously received Occupational (OT). services. The surveyor asked for a copy of the therapy discharge summary. Occupational therapists help people improve their ability to perform daily tasks. (continued on next page)

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	02/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 10:19 AM, review of the 12/11/24 OT discharge summary revealed that the resident was discharged from OT with recommendations for restorative range of motion (ROM) and restorative splint and brace program for [his/her] left hand and to wear a left resting hand splint in the morning after ROM program, for 6-8 hours, and to perform skin checks. On 2/12/25 at 3:12 PM review of the resident's current care plans, including the plan addressing ADL (activities of daily living) self-care performance deficit related to dementia and limited mobility, failed to include documentation to indicate a restorative range of motion program was instituted or that the resident currently had a brace for the left wrist. On 2/13/25 at 2:55 PM, the surveyor asked the Rehabilitation Director (Staff #6) how therapy staff ensured that recommendations were initiated for restorative care, and she replied that recommendations were given to the physician, and once approved, added to the care plan and then added to the nursing tasks. The surveyor notified the Rehabilitation Director of the findings that indicated that there were no care plans for the restorative therapy or splint/brace program. 51900 3)Resident #2 has a medical diagnoses that include diabetes and malnutrition. On 02/11/25 at 8:40 AM the surveyor observed that Resident #2 had a breakfast tray on his/her table that was untouched. The surveyor asked if s/he planed to eat, and the resident replied that s/he needed to be adjusted to reach the food tray. The surveyor alerted one of the Geriatric Nursing Assistants (GNA) who assisted the resident with repositioning. On 02/11/25 at 9:10 AM the surveyor returned to Resident #2's room and observed that s/he ate all of their pancakes. The resident reported that s/he enjoyed their breakfast. On 02/11/25 at 9:59 AM the surveyor conducted a resident representative (RR) interview. The RR expressed concern that Resident #2 isn't given food or snacks that s/he enjoys and has subsequently started bringing in snack items that s/he knows the resident likes. The RR expressed frustration because s/he doesn't think that the staff offer the resident the snacks provided, often finding them untouched or spoiled. Also, the representative was concerned that the lighting in the room often makes it difficult for the resident to see the food. Review of Resident #2's medical record revealed a care plan, that was initiated 2/16/24, to address potential nutritional problem r/t [related to] co morbidities as evidenced by variable po [by mouth] intake, low BMI [body mass index], need for nutritional supplements. A Body Mass Index (BMI) is a measurement of body weight relative to a person's height. A person with a BMI below twenty indicates that the person is underweight. Being underweight can impact a person's ability to fight infections, heal wounds, cause bone density loss, and cause fatigue. According to an 11/15/24 Nutritional Assessment completed by a dietician (Staff #34) revealed that based on the resident's height and weight the BMI was 19.1. This note also revealed documentation indicating the resident was on a weight gain plan. (continued on next page)

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	02/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The stated goal for the nutritional care plan was: [Resident] will not develop complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. This goal was initiated 2/16/24 but had a current target date [date for goal to be addressed and evaluated] of 5/13/25, indicating it had recently been reviewed. Further review of the medical record failed to reveal documentation to indicate the resident suffered from obesity during his/her admission at the facility. Review of the resident's weights between February 2024-February 2025 revealed a range from 125.7 lbs in July to 114.9 in October. On 2/14/25, the Social Service Director #13 provided surveyors with care plan meeting notes, entered as a late entry on 2/14/25, for a meeting that occurred on 11/19/24, which was two days after the dietician's November assessment. This meeting note revealed the following: A care conference was held for the resident with the resident representative attending via phone. The Interdisciplinary Team (IDT) that participated in the meeting included social services, nursing, and activities. Interdisciplinary Team (IDT) is a group of healthcare professionals from different disciplines who work together to provide care for patients. No documentation was found to indicate the registered dietician attended the November care plan meeting, or was involved in the review of the care plan. Further review of the medical record revealed a Nutritional Assessment completed by Dietitian #34 on 2/11/25 that revealed a current BMI of 18.9 and included the following: on weight gain plan w/supplements in place. Further review of the nutrition care plan revealed 3 out of the 4 interventions had been in place since 2/16/24 and included: Administer medications as ordered; Monitor for signs or symptoms of dysphagia (difficulty swallowing); and provide diet as ordered/monitor intake. On 2/11/25 the dietitian #34 added: Provide and serve supplements as ordered: Glucerna BID [two times a day]. The care plan failed to include interventions specific to this resident to encourage meal and snack intake that would assist with weight gain. No documentation was found to indicate the goal of the care plan was updated to reflect the goal of weight gain vs avoiding complications of obesity. On 2/19/25 at 10:06 AM surveyor reviewed the concern with the Nursing Home Administrator #2 that the dietitians note indicates a goal of weight gain, but the care plan does not reflect that goal; and that there was no documentation in the care plan meeting notes to indicate the dietitian participated in the care plan meeting. NHA #2 indicated that her expectation is that if the dietitian cannot physically attend, then they should call in to the meeting. 42886 4) Care Plan - This term refers to document which is the written plan of how a long-term care facility will provide care. This plan is based on resident health assessments, preferences and goals. (continued on next page)

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	02/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/25 at 10:00 AM, the surveyor reviewed complaint MD00212356 sent to the Maryland's Department of Health Office of Health Care Quality Long Term Care Unit in 12/2021. The complaint expressed concern from the resident's family when a comprehensive care plan was not available when the resident's family met for a care planning meeting in 10/2024. Review of Resident #352's's medical records on 2/13/25 at 10:30 AM revealed the resident had his/her initial assessment on 10/17/2024. Further review of resident #352's medical records on 2/13/25 at 10:50 AM revealed that the resident's care plan wasn't completed until 11/7/2024. Review of facility progress notes for resident #352 revealed a progress note from dated 10/30/24 which admitted that the facility failed to complete the comprehensive care plan timely. Interview with the Director of Nursing (DON) on 2/18/24 at 11:00 AM regarding the facility's failure to complete resident #352's comprehensive care plan timely. The DON confirmed that the facility failed to complete resident #352's comprehensive care plan timely.

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	02/20/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45139 Based on review of pertinent documentation and interviews it was determined that the facility failed to have comprehensive care plan meetings at the required intervals and failed to update the care plan after a change in status. This was evident for 3 (Resident # 8, #2 and #337) out of 42 residents reviewed during a survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1) On 2/17/25, the review of intake #MD00207198 revealed that Resident #8, a long-term resident of the facility, had a concern that the facility was not developing compressive care plans for the facility residents. On 2/18/25 at 9:29 AM Resident #8 was interviewed. During the interview s/he confirmed that s/he had made several complaints to the facility and to the Office of Healthcare Quality regarding the comprehensiveness of his/her care plan. Resident #8 reported that the concern with his/her care plan had not been resolved. On 02/18/25 11:18 AM the Director of Nursing (DON) and the Social Service Director (SSD Staff #13) were interviewed. During the interview the DON and the Social Service Director reported that a care plan documentation includes who is in attendance during the care plan meeting. The expectation is that the Social Service Director, the Dietitian and the Activities Director should attend the meetings. Additionally, the care plan meetings should be held after the admission comprehensive assessment and then following every quarterly comprehensive assessment that is documented in a Minimum Data Set (MDS). On 2/18/25 review of medical records revealed that Resident #8's MDS was completed in March 2024, June 2024, September 2024 and December 2024. Continued review of medical records failed to reveal documentation that a care plan conference was held following the September and December MDS assessments. On 2/19/25 at approximately 11:30 AM during an interview with the Social Service Director #13, she confirmed that the resident had not had a care plan following the completion of his/her December 2024 MDS documentation. She reported that the resident postponed and then declined attending the care plan meetings. However, she confirmed that the facility policy is that care plan meetings are still held if the residents are not in attendance. On 2/19/25 at 12:23 PM all concerns discussed with the Nursing Home Administrator #2. She acknowledged the concerns. No additional information was provided prior to survey exit on 2/19/25 at 4:00 PM. 51900 (continued on next page)

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	02/20/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #2 has a medical history of dementia but review of the 11/21/24 Minimum Data Set (MDS) Section B, which evaluates hearing and speech, revealed the resident was able to make themselves understood and is able to understand others. A Minimum Data Set is a standardized assessment tool that helps to evaluate the health status of residents in long-term care facilities. The information gathered helps facilities to develop patient-centered care plans based on the resident's unique needs. The MDS assessment is a mandated requirement for all residents. On 2/10/25 at 12:53 PM, resident was observed feeding self lunch and was able to tell surveyor that s/he was enjoying the lunch. On 2/11/25 at 9:53 AM, the surveyor spoke with Resident #2's representative who expressed concerns that [s/he] isn't involved with the resident's care decisions. The representative stated that [s/he] wasn't sure if they had attended care plan meetings but confirmed that there have been conference calls. On 2/13/25 at 3:11 PM, a medical record review revealed a care plan meeting occurred on 2/27/24. Further review of the medical record failed to reveal documentation to indicate a care plan meeting had occurred since February 2024. On 2/13/25 at 3:50 PM, the Activities Director (Staff #32) was asked if she attends care plan meetings and the Activity Director replied that she doesn't usually participate in care plan meetings, that she has been invited, but if she is busy, she doesn't attend. On 2/14/25 at 9:26 AM, the surveyor interviewed the Social Services Director (SSD- Staff #13) regarding how she schedules care plan meetings with families. The SSD stated that she keeps a calendar based on the Minimum Data Set (MDS) assessment dates and tries to reach resident representatives to invite them to the meetings. When she is unable to reach the representatives, she writes a progress note. The surveyor reviewed the concern that documentation was found for only one care plan meeting, which was held in February of 2024, and asked if there was any additional documentation to indicate other care plan meetings had occurred. On 2/14/25 at 11:31 AM the Social Service Director presented with a note, dated 8/23/24 that indicated the resident's responsible representative was informed of a meeting scheduled for 8/27/24 and that the representative may not be available, the note included: If the [representative] is not available the meeting will be rescheduled for the following week. The Social Service Director was unable at this time to say if a meeting was rescheduled as indicated in the 8/23/24 note. On 2/14/25 at 1:34 PM the SSD confirmed the meeting for 8/27 was not held or re-scheduled. On 2/14/25, the SSD provided surveyors with care plan meeting notes, entered into the electronic health record as late entries on 2/14/25, for meetings that occurred on 5/21/24 and 11/19/24. Both these meeting notes revealed the following: A care conference was held for the resident with the resident representative attending via phone. The Interdisciplinary Team (IDT) that participated in the meeting included social services, nursing, and activities. (continued on next page)

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	02/20/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interdisciplinary Team (IDT) is a group of healthcare professionals from different disciplines who work together to provide care for patients. No documentation was found in either the May or November notes to indicate why the resident was not present for the meetings, or if the resident was invited to attend. No documentation was found to indicate the registered dietician attended the care plan meetings, or was involved in the review of the care plan. There was a note from 8/27/24 which reads: Social Services (SS) attempted to reach out to the resident representative for care conference. The IDT did chart review. Patient is stable. No changes to MOLST. Pt. does not have funeral home arrangements. Activity preferences remain the same. No changes to diet orders. This note failed to include which disciplines did chart review or if an actual meeting occurred with the IDT. On 2/14/25 at 1:34 PM, review of the 5/21/24 note, which was written by the SSD more than six months after the meeting occurred, revealed documentation that nursing and activities attended the care plan meeting. When asked who from nursing attended the meeting, as documented in the note, SSD reported [name of the ADON] because she was the unit manager and always attended. The SSD was unable to provide the name of the activity staff that attended, and confirmed activities staff did not always attend the meetings. On 2/18/25 at 10:45 AM, the surveyor reviewed Resident #2's medical record which revealed MDS assessments with assessment references dates of 5/23/24, 8/22/24, and 11/21/24. An assessment reference date (ARD) is the last day of the observation period that serves as the look-back period of an MDS assessment. According to state regulations, the nursing home shall hold the care planning conference not later than 7 calendar days after completing the assessment, but may hold the conference sooner if agreed to by the resident, a family member, or a resident's representative. No documentation was found to indicate the resident representative agreed to having the care plan meeting prior to the completion of the assessments in May or November. On 2/19/25 at 10:06 AM the surveyor reviewed concerns with the Nursing Home Administrator (NHA #2) regarding the fact that the meetings were held prior to the Assessment Reference Date (ARD) and that the August 2024 meeting was not re-scheduled. 42886 3) Care Plan - This term refers to document which is the written plan of how a long-term care facility will provide care. This plan is based on resident health assessments, preferences and goals. On 2/13/25 at 12:27pm, the surveyor reviewed complaint MD00178395 sent to the Maryland's Department of Health Office of Health Care Quality Long Term Care Unit in 12/2021. The complaint expressed concern from the resident has he/she was not receiving rehabilitation during his/her visit in the 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
	215327	A. Building B. Wing	02/20/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #337's medical records on 2/13/25 at 12:30 PM revealed the resident had a care plan to prevent falls. Further review of Resident # 337's medical records on 2/14/25 at 8:40 AM revealed that the resident had a fall on 11/17/21. The resident was sent to the local hospital for xrays and treatment. Review of the care plan after the 11/17/21 fall incident found no updates to the fall care plan to assist in the prevention of falls and subsequent injuries from falls. Interview with the Director of Nursing (DON) on 2/18/24 at 11:00 AM regarding the facility's failure to update Resident #337's care plan after a fall incident on 11/17/21. The DON confirmed that the facility failed to update Resident #337's care plan after the fall incident on 11/17/21.

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	02/20/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 51900 Based on observations, interviews, and record review it was determined that the facility failed to provide activities to meet the needs of the resident. This was found to be evident for 1 (Resident #2) out of 3 residents reviewed for activities during the survey. The findings include: Resident #2 has resided at the facility for approximately one year and has a history of stroke and dementia. A review of the admission Minimum Data Set assessment, with an assessment reference date of 2/22/24, revealed the Preferences for Customary Routine and Activities was conducted with the resident representative. This assessment revealed that music and getting fresh air were very important to the resident. The Minimum Data Set (MDS) is a standardized assessment tool that helps to evaluate the health status of residents in long-term care facilities. The information gathered helps facilities to develop patient-centered care plans based on the resident's unique needs. The MDS assessment is a mandated requirement for all residents. On 2/10/25 at 3:10 PM, the surveyor observed Resident #2 sleeping in bed. On 2/10/25 at around 3:45 PM, the surveyor observed Resident #2 in bed with a crossword puzzle on the bedside table placed in front of the resident. On 2/11/25 at 9:46 AM, the surveyor conducted a resident representative interview for Resident #2 who expressed concerns that the resident is regularly in his/her room and not participating in activities. On 2/12/25 at 3:21 PM, a review of the current activities care plan revealed the following interventions: *The resident will maintain involvement in cognitive stimulation, and social activities as desired through the review date. *The resident will express satisfaction with the type of activities and level of activity involvement when asked through the review date. *The resident will maintain involvement in cognitive stimulation, and social activities as desired through the review date. *The resident will participate in activities of choice such as watching movies or having social hours 3-4 times per week by the review date. (continued on next page)

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	02/20/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 3:27 PM, the surveyor reviewed a note from the Activities Director (Staff #32) dated 2/12/25, the review of the note revealed that the Activity Director determined that the resident was alert, oriented, and capable of communicating his/her needs and had chosen not to participate in the activity program (the resident has no interest in participating in the activities program) and that they would continue to encourage him/her to attend group activities and receive 1:1 interventions as well as visit resident on a social basis daily. Further record review failed to reveal other progress notes from activities within a three-month look back (11/12/24-2/12/25). On 2/13/25 at 9:20 AM, the surveyor observed Resident #2 in his/her room in bed, in a hospital gown, with the lights off. On 2/13/25 at 3:22 PM, the surveyor observed Resident #2 in bed wearing a hospital gown with the lights off. On 2/13/25 at 3:50 PM the Activities Director (Staff #32) was asked if she attends care plan meetings and the Activity Director replied that she doesn't usually participate in care plan meetings, that she has been invited, but if she is busy, she doesn't attend. She informed the surveyor that she completed part of the MDS assessment and attended the 72-hour meetings. The surveyor then asked the Activity Director how the activities team keeps track of attendance in activities events. She responded that the staff keeps attendance logs and that the notes are kept in the medical records system but when the surveyor asked to see the notes she then stated that they are not in the medical record, but in a binder that is kept in her office. The surveyor then asked if Resident #2 attended activities. She replied that Resident #2 prefers to stay in his/her room and that the team conducts 1:1 activities. The surveyor asked for records of the 1:1 visits, and she stated that she doesn't keep documentation of the visits. The surveyor then asked how she tracks 1:1 visits for each resident, and she stated that 1:1 visits are included in the monthly facility activity calendar. The calendar was not resident-specific but rather a master calendar that included 1:1 visits. The Nursing Home Administrator (NHA) (Staff #2) joined the interview with the Activity Director and overheard this part of the conversation. She stated that they need to revise the current process and will start documenting activities participation. The surveyor then reviewed with the Activity Director and NHA #2 that the care plan for Resident #2 indicated that they like social hours and do attend. The surveyor asked if there was documentation to support that Resident #2 attended the social hours and the Activity Director stated that they sometimes write the names on a piece of paper. The surveyor asked for records that show participation in any activities or any 1:1 activities. The Activity Director indicated the documentation was in her office and the surveyor accompanied her to the office. On 2/13/25 at 4:11 PM, while in the activity office, the Activity Director showed the surveyor several sheets of paper that included a variety of resident names that the Activity Director indicated was documentation of participation in group activities. Further review of these sheets failed to reveal the date, time, or activity that had occurred. (continued on next page)

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	02/20/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the surveyor requested documentation specific to Resident #2's participation, the Activity Director presented the surveyor with a document with the following statement at the top: Resident[s] who actively participated in large group activities for the month of January. Unit [#]: Resident on unit [#], on Tuesday's, Wednesday's, and Thursday's starting from 11:30 am to 12:30 pm receive 1.1 interventions in their rooms weekly. These residents also have the option of participating in large group activities as well as staying in their rooms, The following residents participate in large group activities on the 2nd floor. This document then lists a total of 43 residents with a brief statement following each resident's name. The statement following Resident #2's name included: Resident participates in all large group activities, [s/he] participates at least 2-3 times a week, twice a day monthly. When medically stable. Similar summary documents were provided for December and November. Of note, no year was documented on these reports. For December and November, staff documented the following for Resident #2: Resident participates in all large group activities, [s/he] participates at least 7 times a week, twice a day monthly. When medically stable. The facility failed to reveal documentation that the resident attended activities or was offered individualized activities, such as listening to music or enjoying fresh air, which was determined in the MDS to be very important to the resident.

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	02/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45139 Based on record reviews, interview and observations it was determined that the facility failed to have an effective system in place to ensure physician orders were put in the electronic health record for implementation, and failed to ensure orders and a care plan were established for the use of safety equipment. This was found to be evident for 3 (Resident #12, #30 and #66) out of 42 residents reviewed during the survey. The findings include: 1)On 2/12/25 at 10:25 AM Resident #12, a Resident admitted to the facility for rehabilitation, medical records were reviewed. Further review revealed the residents had several orders for opioid medications. On 2/12/25 at 10:30 AM a review of a pharmacy review, dated 5/23/24 revealed a pharmacist recommendation for the resident to have an order for Naloxone in case of a opioid overdose. Further review revealed that a physician agreed with the recommendations and ordered Naloxone for Residents #12. On 2/12/25 at 10:39 AM the review of Resident #12 orders failed to reveal an order for Naloxone. On 2/14/25 at 1:42 PM interview with the unit nurse manger that worked on Resident #12's unit reported that she was unaware of the Naloxone order and would review the pharmacist recommendation paperwork. On 2/13/25 at 3:50 PM the Director of Nursing (DON) was interviewed. During the interview the DON reported that there must have been an error in their pharmacy review process on that day. She confirmed that the facility failed to follow through and implement a physician's order. On 2/15/25 the review of Resident # 12's orders revealed an order for Naloxone HCl 0.4 MG/ML Solution, Inject 1 ml intramuscularly as needed for narcotic overdose. 02/19/25 12:23 PM concerns of the missing order were discussed with the Nursing Home Adminstrator #2. No additional information was provided prior to the survey exit at 4:00 PM. 2)On 2/12/25 at 2:50 PM Resident #30's, a resident receiving rehabilitation at the facility, medical records were reviewed. Review of the progress notes revealed a nursing note dated 2/10/25. The note documented that the resident has a skin tear on the right inner thigh measuring 0.2cm x 4.0 cm and the Nurse Practitioner (NP) was notified, and new orders were given to clean the area with wound cleanser, apply Xeroform and cover the wound with bordered gauze daily. On 2/12/25 at 2:52 PM a review of orders failed to reveal an order for Xeroform and cover the wound with bordered gauze daily. On 2/12/25 at 2:58 PM a review of the February Medication Administration Record (MAR) failed to reveal documentation that the wound was cleaned and covered according to orders. (continued on next page)

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	02/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 3:01 PM Review of progress notes failed to reveal any documentation that the skin tear was treated according to orders. On 2/13/25 at 3:50 PM the Director of Nursing (DON) was interviewed. During the interview the DON confirmed that the nurse who received the order failed to follow through/implement the physician's order. On 2/14/25 review of resident's orders revealed the following order dated 02/13/25 at 4:19 PM: Cleanse right inner thigh open area with wound cleanser, pat dry, apply Xeroform and cover with bordered gauze daily until resolved, every evening shift for Wound care. 51900 2) Resident #66 has a medical history of a subdural hemorrhage (brain bleed). The resident now suffers from a seizure disorder. On 2/10/25 at 10:22 AM, the resident was observed in bed. A helmet was observed on top of the resident's dresser at this time and was not on the resident's head at the time of this observation. A helmet can be used as protective headgear that reduces the risk of injury for patients with seizure disorders. On 2/11/25 at 8:52 AM, the surveyor observed Resident #66 in bed with a helmet on [his/her] head. On 2/12/25 at 10:10 AM, review of the medical record, including physician orders and the current care plans, failed to reveal documentation regarding the use of the helmet. On 2/12/25 at 1:15 PM, a review of geriatric nursing assistant (GNA) tasks in the electronic health record failed to reveal a mention of Resident #66's helmet. On 2/13/25 at 10:11 AM, the surveyor interviewed GNA (Staff #28) about the care provided for Resident #66. The GNA #28 stated that the helmet should always be on unless care is being given and that she only removes it to wash the resident's hair. The surveyor asked how she knew what to do with the helmet and she stated they (the facility staff) told her. The GNA stated that she knows from experience at her previous job that it is supposed to be on the care plan, but hasn't seen it on the resident's care plan. On 2/13/25 at 12:37 PM, during an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) the surveyor reviewed the concern that the resident is wearing a helmet but no documentation was found in the medical record addressing the use of this device, including no orders or mention in the care plans. The DON verbalized awareness of Resident #66's helmet and both the DON and ADON verbalized the rationale for the use of the helmet. The DON stated It's for the resident's protection. On 2/18/25 at 12:22 PM, the surveyor observed Resident #66 in bed with the helmet on. (continued on next page)

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	02/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/2025 at 10:00 AM, further record review revealed a an order for the helmet entered on 2/16/25: Helmet: apply to the head all the time (remove during Adl's care) for protection due to right subdural hematoma and hydrocephalus s/p craniectomy/cranioplasty, Hydrocephalus s/p Certa's shunt complicated by intracranial abscess. Activities of Daily Living (ADL) care are basic tasks such as bathing and dressing. The remaining description in the orders refers to Resident #66's medical and surgical history which includes: Subdural hematoma-bleeding in the brain; Hydrocephalus- excess fluid in the brain; Craniectomy/Cranioplasty- removal and replacement of the skull bone; Certas Shunt- a valve surgically inserted that regulates fluids in the brain; and Intracranial Abscess- fluid-filled swelling in the brain. On 2/19/25 at 11:06 AM, further record review revealed another order dated 2/18/25 stating, Remove helmet every four hours for 15 minutes.

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	02/20/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 51900 Based on record review and staff interview, it was determined that the facility failed to ensure wound treatment recommendations were implemented in a timely manner. This was evident for one (Resident #66) out of four residents reviewed for pressure ulcers. The findings include: A review of Resident #66's medical record revealed the resident was readmitted to the facility after a more than one-week hospitalization in late December 2024. On 02/12/25, a review of Resident #66's medical record revealed a 1/7/25 Minimum Data Set assessment, which indicated that the resident had one stage two pressure ulcer present on admission. A Pressure Ulcer (PU) is a skin injury caused by prolonged pressure on an area of the body. Pressure ulcers result from restricted blood flow to tissues resulting in skin breakdown, open sores, or ulcers. Review of the January 2025 Treatment Administration Record failed to reveal treatment orders for a pressure ulcer between 1/1- 1/7/25. Further review of the medical record revealed that on 1/7/24 the wound care specialist saw the resident and recommended an order which was implemented on 1/8/24: Cleanse the sacral wound with wound cleanser and apply Dermaseptin to the base of the wound, leave open to air, performed twice daily. Review of the TAR revealed this order was in place and implemented until it was discontinued on 1/19/25. The wound care specialist saw the resident again on 1/14/25 and recommended a change to the resident's sacral pressure ulcer treatment to: Cleanse sacrum PU unstageable wound area with wound cleanser; pat dry, apply Med-honey plus calcium alginate, and covered with bordered gauze, performed BID (twice daily). An order based on this recommendation was entered on 1/19/25, this was five days after the wound specialist made the recommendation. Med-honey is used in the treatment of pressure ulcers to remove dead tissue, and because it has an antibacterial effect it discourages infections and promotes wound healing. Calcium Alginate absorbs excess moisture and promotes wound healing. On 2/13/25 at 12:37 PM, the surveyor conducted an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) about the process regarding wound care orders. The DON stated that when the wound care nurse makes a recommendation, it is shared with the physician, and then a request is made for the new order. The unit managers facilitate the process of obtaining and following through on the new order request. (continued on next page)

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	02/20/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 2:12 PM, the surveyor met with the DON and reviewed the concern regarding the multiple day delay from the time the wound specialist made their recommendation until the orders were initiated.

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	02/20/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 51900 Based on record review, staff interview, and observation, it was determined that the facility failed to have an effective system in place to ensure therapist recommendations were implemented. This was evident for one (Resident #19) out of three residents reviewed for activities of daily living. The findings include: Resident #19 had a history of a cerebral infarction (stroke) that resulted in contracture of the muscles in the left hand. A contracture is a shortening and hardening of the muscles and tendons that may lead to deformity or rigidity of the joints. On 2/10/25 at 2:44 PM, the Rehabilitation Director (Staff #6) reported that Resident #19 had previously received Occupational (OT). services The surveyor asked for a copy of the therapy discharge summary. Occupational therapists help people improve their ability to perform daily tasks. On 2/11/25 at 10:19 AM, review of the 12/11/24 OT discharge summary revealed that the resident was discharged from OT with recommendations for restorative range of motion (ROM) and restorative splint and brace program for [his/her] left hand and to wear a left resting hand splint in the morning after ROM program, for 6-8 hours, and to perform skin checks. After further review of the medical record, no documentation was found to indicate the resident was referred for restorative nursing care or a restorative splint or brace program. Restorative range of motion is a planned program of exercises, either active (resident moves their joints independently) or passive (staff moves the resident's joints for them), intended to maintain or improve a resident's joint mobility and flexibility, aiming to prevent contractures and promote independence in daily activities. A restorative splint or brace program is when a patient is provided with a custom splint or brace, which is regularly adjusted and monitored to help gradually improve their range of motion and function in a specific body part, and assist to regain lost abilities. On 2/12/25 at 3:12 PM the surveyor was unable to find care plan interventions, physician orders or nursing assistant tasks specific to Resident #19's restorative ROM, or a splint and brace program. On 2/13/25 at 2:31 PM the surveyor observed Resident #19 in bed wearing a hospital gown, with no splint noted on their left hand. (continued on next page)

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	02/20/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 2:32 PM, the surveyor spoke with Geriatric Nursing Assistant (GNA#18) about how she provided ROM exercise with residents. She stated that she sometimes does ROM with the therapist present and that therapy staff trained her to perform ROM with residents. When asked if she performed ROM for Resident #19, she stated that the resident often said [s/he's] in pain and didn't want to participate and that when [s/he] refused, that GNA #18 reported that to a nurse. She stated that the resident had no brace that she was aware of. On 2/13/25 at 2:55 PM, the surveyor asked the Rehabilitation Director (Staff #6) how therapy staff ensured that orders were initiated for restorative care, and she replied that recommendations were given to the physician, and once approved, added to the care plan and then added to the nursing tasks. She stated that therapy staff trained the GNA's to perform ROM care with the residents. The surveyor notified the Rehabilitation Director of the findings that indicated that there were no care plans or orders for the restorative therapy or splint/brace program. She stated that she would look for records and follow up with the surveyor. On 2/13/25 at 3:21 PM the surveyor observed that Resident #19's splint was on the resident's left hand/forearm. On 2/13/25 at 3:31 PM, the Rehabilitation Director provided the surveyor with Geriatric Nursing Assistant (GNA) documentation entitled Nursing Rehab and Assistance with Splint or Brace to the Left Upper Extremity but stated that it was confusing and didn't accurately reflect the therapy recommendations. The document had four columns with title headers: amount, resident not available, resident refused, and not applicable. The column titled amount didn't specify the meaning of amount, and when the surveyor asked the Rehabilitation Director to explain, she stated that those were the number of minutes that the resident wore the splint. According to the GNA documentation, from 1/31/25 to 2/12/25 the resident wore the splint as follows: On 1/31/25, 2/4/25, 2/7/25, and 2/12/25 the resident wore the brace for 15 minutes daily. On 2/5/25, 2/10/25, and 2/11/25 the resident wore the brace for 15 minutes, twice daily. On 2/6/25 the resident wore the brace for 10 minutes during the morning shift and 15 minutes during the evening shift, and on 2/9/25 the resident wore the brace for 4 minutes in the morning and 15 minutes in the evening. The response not applicable was entered on 1/31/25, 2/1/25, 2/2/25 (AM and PM), 2/4/25, 2/7/25, and 2/8/25. (continued on next page)

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	02/20/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While reviewing the GNA rehabilitation task documentation (Nursing Rehab: Assistance with Splint or Brace LUE [left upper extremity]) section of the electronic health record with the Rehabilitation Director, she was able to provide a view of the medical record that was not easily accessible to the surveyor, which stated: [NAME] [put on] LUE resting hand splint in AM, doff [remove] in PM; do not apply splint more than 8 hours at a time. Perform skin checks before and after splint use. The Rehabilitation Director confirmed that the facility is not accurately performing the splint care. On 2/19/25 at approximately 2:12 PM, the surveyor reviewed the findings with the Director of Nursing about the failure to ensure that therapist recommendations were implemented regarding the restorative ROM and splint/brace recommendations.

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	02/20/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48168 Based on observation, interview, and record review, it was determined that the facility failed to obtain a physician's order for oxygen use. This was evident for 1 (Resident #287) of 6 residents reviewed for respiratory care during the recertification survey. The findings include: On 2/10/25 at 12:15 PM Resident #287 was observed seated on the bed in his/her room. There was an oxygen nasal cannula tubing in his/her nose and the tubing was connected to an oxygen concentrator next to the resident's bed and the concentrator was set to deliver oxygen at 1 liter/minute. When the resident was asked how long he/she had used oxygen, the resident replied that he/she had used oxygen since his/her admission in January. On 2/13/25 at 3:16 PM a review of Resident #287's physicians orders failed to reveal any order to give the resident oxygen. On 2/13/25 at 3:46 PM Resident #287 was again observed in his/her bed with the oxygen nasal cannula in place and connected to an oxygen concentrator which was set at 1 liter/minute. On 2/13/25 at 3:47 PM the surveyor asked Registered Nurse (RN #4) to check Resident #287 and assess if the resident had oxygen in use, and at what setting. RN #4 went with the surveyor to Resident #287's room and verified that the resident had oxygen in use at 1 liter/minute. On 2/13/25 at 4:08 PM an interview with the incoming Nursing Home Administrator (NHA#2) was conducted to review the finding that Resident #287 lacked an order to use oxygen. The incoming NHA confirmed that she knew there was no order for the resident's oxygen use. On 2/18/25 at 3:35 PM an interview with the interim NHA (NHA #1), he confirmed the finding that Resident #287 lacked a physician order for oxygen use.

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	02/20/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 48168 Based on record review and interview it was determined that the facility failed to ensure that providers accurately reviewed residents' medications. This was evident for 1 (Resident #74) of 5 residents reviewed for unnecessary medications during the recertification survey. The findings include: On 2/12/25 at 9:45 AM a review of Resident #74's prescribed medications was conducted and revealed that the resident had previously been prescribed quetiapine (an antipsychotic medication) for agitation, but it was discontinued on 12/26/24. On 2/12/25 at 11:12 AM a review of Resident #74's Nurse Practitioner (NP) notes revealed 2 clinical notes, one written on 1/31/25 and one written on 2/10/25 by NP #9. Both notes included documentation that quetiapine was an active and current medication. On 2/18/25 12:29 PM a telephone interview with NP #9 was conducted to review his documentation of Resident #74's medication evaluations on 1/31/25 and 2/10/25. During the interview, NP #9 reviewed his notes and the resident's medication order history. When asked why his documentation indicated that the resident continued to have quetiapine prescribed, but the medication was discontinued on 12/26/24, he confirmed that his documentation was inaccurate. When asked about his medication review process, he said that he visited residents to assess them, and looked in the medical record to review medications but that he probably overlooked the medication and apologized for the error. On 2/18/25 at 3:35 PM an interview with the Nursing Home Administrator (NHA) was conducted to review that NP #9 inaccurately evaluated Resident #74's medications. The NHA said he understood, and he did not offer any additional information.

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	02/20/2025

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 51900 Based on record review and staff interviews, it was determined that the facility failed to have a resident seen by a physician for more than 9 months. This was evident in one (Resident #2) out of three residents reviewed for nutrition. The findings include: On 02/18/25 at 11:30 AM, review of Resident #2's medical record failed to reveal documentation to indicate the resident was seen by a primary care physician, or a nurse practitioner, from August 2024 until 12/30/24. The Director of Nursing and Assistant Director of Nursing were made aware of this concern at this time. The ADON indicated she would check the medical record from her laptop computer. Further review of the medical record failed to reveal documentation to indicate the resident was seen by the primary care physician from March through November 2024. On 02/18/25 at 11:46 AM, the ADON presented with her computer and failed to find primary care provider notes for August through November via her laptop at this time. The surveyor also reviewed the concern that there was no documentation to support that Resident #2 was seen by a Primary Care Physician from March 2024 through November 2024. The ADON indicated that the physician did see the resident and indicated she would follow up regarding the notes. On 2/19/25 review of additional documentation provided by the facility staff revealed Nurse Practitioner Progress Notes dated 8/13/24, 8/20/24, and 8/27/24, but the Author was listed as [Staff #33's name] - Physician. Further review of the documentation provided revealed the resident was seen on multiple occasions in September, October, and November 2024 by Staff #33. The Staff #33 was identified in the Author section of the September notes as a physician and in the October and November notes as a Physician Assistant. On 2/19/25 at 10:06 AM surveyor requested clarification from Nursing Home Administrator (NHA #2) regarding Staff #33's credentials since the notes provided indicated they are nurse practitioner notes but Staff #33's signature indicates different titles including physician and physician assistant. At 12:00 PM the NHA #2 reported that Staff #33 is a nurse practitioner. The NHA also reported having spoken with the physician who indicated s/he had seen the resident. On 02/19/25 at 2:12 PM, the surveyor expressed to the DON the concern that no documentation has been provided to indicate the physician saw the resident for several months. The DON stated that she was working on getting the records. As of 02/21/25, the facility had failed to provide documentation that Resident #2 was seen by a physician during the 9 months between February and December 2024.

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	02/20/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 48470 Based on record review and interviews it was determined that the facility failed to administer a resident's medication according to physicians ordered parameters. This was evident for 3 (Resident #51, #48 and #8) out of 5 residents reviewed for unnecessary medications during a survey. The findings include: Hypertension (HTN), also known as high blood pressure (BP), is a condition in which the force of blood against the walls of the arteries is consistently too high. It is defined as a systolic blood pressure (SBP top number) of 130 mmHg or higher, or a diastolic blood pressure (DBP bottom number) of 80 mmHg or higher, based on multiple blood pressure measurements. 1) Resident #51 had been residing in the facility since 2023. A review of Resident #51's medication orders was conducted on 2/13/25 at 11:44 AM. The review revealed an order for Amlodipine Besylate oral tablet 10 mg, with instructions that read Give 1 tablet by mouth one time a day for HTN Hold for SBP <110 or heart rate (HR) <60. Review of Resident #51's electronic Medication Administration Record (eMAR) for the month of January 2025 was conducted on 2/13/25 at 11:48 AM. The review revealed the Amlodipine Besylate order was scheduled to be administered every day at 9 AM and had an area for the nursing staff to document the resident's BP and HR. The concerns identified in this review include: a) Administered on 1/3/25 by Licensed Practical Nurse (LPN #22) with a SBP of 109 b) Administered on 1/8/25 by LPN #22 with a SBP of 103 c) Administered on 1/10/25 by LPN #22 with a SBP of 105 d) Administered on 1/16/25 by LPN #22 with a HR of 55 e) Administered on 1/18/25 by LPN #23 with a HR of 53 f) Administered on 1/25/25 by LPN #22 with a SBP of 105 g) Administered on 1/27/25 by LPN #22 with a SBP of 102 h) Administered on 1/28/25 by LPN #22 with a HR of 46 i) Administered on 1/30/25 by LPN #22 with a HR of 52 j) Administered on 1/31/25 by LPN #22 with a SBP of 108 (continued on next page)

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	02/20/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent review of Resident #51's eMAR for the month of February 2025 was conducted on 2/13/25 at 12:16 PM. The review revealed the Amlodipine Besylate order was scheduled to be administered every day at 9 AM and had an area for the nursing staff to document the resident's BP and HR. The concerns identified in this review include: a) It was held on 2/1/25 by LPN #23, but did not document Resident BP or HR. A quick review of Resident #51's vitals list for 2/1/25 indicated a BP of 119/66 mmHg at 9:15 AM and a HR of 70 at 9:22 AM. b) Administered on 2/2/25 by LPN #23 with a SBP of 104 and a HR of 56 c) Administered on 2/3/25 by LPN #22 with a SBP of 98 d) Administered on 2/9/25 by LPN #22 with a SBP of 104 e) Administered on 2/10/25 by LPN #22 with a SBP of 108 f) Administered on 2/11/25 by LPN #22 with a SBP of 92 On 2/18/25 at 10:32 AM, the eMAR was reviewed with the Director of Nursing (DON). The DON indicated that in some cases; after discussing with the physician, they may have instructed the nursing staff to still administer the medication even when the HR or SBP was outside the parameters. If that was the case, the DON reported that there would be a note that would indicate this instruction and indicated that she would review Resident #51's medical records. After the review, the DON reported on 2/18/25 at 2:03 PM, that she was not able to find any note to indicate the medication can be given outside its given parameters. The DON verbalized understanding and acknowledged the concern. 2) Resident #48 was admitted to the facility in the first quarter of 2023. A review of Resident #48's medication orders was conducted on 2/12/25 at 11:25 AM. The review revealed 2 medication orders for HTN: Lisinopril oral tablet 10 mg, with instructions that read Give 1 tablet by mouth one time a day Hold for SBP less than 110, HR less than 60; and Hydralazine oral tablet 25 MG, with instructions that read Give 0.5 tablet by mouth three times a day for HTN hold for SBP less than 110, HR less than 60. Resident #48's eMAR for the month of January 2025 was conducted on 2/12/25 at 11:29 AM. The review revealed the 2 medications ordered for HTN were administered outside the given parameters on several occasions. The identified administration dates and times were: a) Lisinopril was administered on 1/15/25 at 9 AM by nurse (Staff #24) with a HR of 53 b) Lisinopril was administered on 1/23/25 at 9 AM by LPN #22 with a HR of 54 c) Lisinopril was administered on 1/24/25 at 9 AM by LPN #25 with a SBP of 107 d) Hydralazine was administered on 1/15/25 at 2 PM by Staff #24 with a HR of 52 (continued on next page)

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	02/20/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e) Hydralazine was administered on 1/23/25 at 2 PM by LPN #22 with a HR of 54 f) Hydralazine was administered on 1/30/25 at 10 PM by LPN #26 with a HR of 55 g) Hydralazine was administered on 1/31/25 at 6 AM by LPN #22 with a HR of 55 On 2/18/25 at 10:32 AM, the eMAR was reviewed with the Director of Nursing (DON). The DON indicated that in some cases; after discussing with the physician, they may have instructed the nursing staff to still administer the medication even when the HR or SBP was outside the parameters. If that was the case, the DON reported that there would be a note that would indicate this instruction and indicated that she would review Resident #48's medical records. After the review, the DON reported on 2/18/25 at 2:03 PM, that she was not able to find any note to indicate the medication can be given outside its given parameters. The DON verbalized understanding and acknowledged the concern. 45139 3)On 2/12/25 at 10:25 AM Resident #12's, a Resident admitted to the facility for rehabilitation, medical records were reviewed. Further review revealed that the resident was ordered the high blood pressure medication Amlodipine Besylate. The physician ordered Resident #12 to receive the medication every day except when the Resident blood pressure was lower than 110 systolic (the top number of a blood pressure reading). On 2/12/25 at 10:57 AM Resident #12's medication administration record (MAR) was reviewed for the months of January 2025 and February 2025. The review revealed that the medication was administered outside the order parameters 6 times in January 2025 and twice during the period from February 1st through February 13th. On 2/14/25 at 9:28 AM the Director of Nursing confirmed the concerns that the blood pressure medication was documented as administered outside the parameters of the physician's order. No additional information was provided prior to survey exit on 2/19 at 4:00 PM.

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	02/20/2025

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 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. 48168 Based on observation and interview it was determined that the facility failed to ensure medications were kept in locked compartments and maintained under proper temperature controls. This was found to be evident during one out of four medication pass observations (Resident #55), one random observation (Resident #354); and for two out of two medication storage rooms observations. The findings include: 1) On 2/13/25 at 11:14 AM an observation of medication administration for Resident #55 was conducted. The facility Certified Medicine Aide (CMA #12) was observed at the medication cart in the hallway outside the resident's room. On 2/13/25 at 11:15 AM CMA #12 removed 2 bottles of stock medications, viewed the computer screen on top of the medication cart, and then returned the bottles to the drawer, and said that she needed to go get something, closed the medication drawer and walked away from the cart. On 2/13/25 at 11:17 AM an interview was conducted with the unit nurse manager (Staff #21) who was in the hallway a few feet away from the medication cart. The unit nurse manager #8 was asked to verify if the medication cart was locked, and she verified that the cart was unlocked and stated that the cart should have been locked when the CMA #12 walked away and left it unattended. On 2/13/25 at 11:19 AM CMA #12 returned to the medication cart and unit nurse manager #21 confirmed with the CMA that she had left the unattended medication cart unlocked and should not have done so. On 2/13/25 at 2:50 PM an interview with the Director of Nursing (DON) was conducted to review the finding that CMA #12 left an unattended medication cart unlocked. The DON said she had been informed of the deficiency, and she provided no other information. On 2/18/25 at 3:35 PM an interview with the Nursing Home Administrator (NHA #1) was conducted to review the survey deficiencies. He provided no additional information. 16218 2) On 2/10/25 at 12:42 PM surveyor observed a humalog insulin quickpen for Resident #354 in a clear plastic bag sitting on a medication cart in the hallway just outside of Resident #354's room. Resident #354 was observed in a wheelchair in the room. Resident #79 (Resident 354's roommate) was also observed in the room and was ambulating toward the doorway at the time of the observation. No nursing staff was observed in the area at the time of this observation. Surveyor continued observing the unattended insulin pen until the nurse (Staff #15) arrived at the medication cart at 12:45 PM. Nurse #15 reported she had gone to obtain other insulin from the refrigerator, surveyor reviewed the concern with the nurse that the insulin was left unattended on top of the medication cart. (continued on next page)

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	02/20/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/25 at 3:26 PM surveyor reviewed the observation of the unattended insulin with the Director of Nursing. 3) On 2/14/25 at 10:20 AM observation, with the Assistant Director of Nursing (ADON), of the first floor medication room's refrigerator revealed a thermometer inside the refrigerator reading 30 degrees F. Surveyor observed that insulin was being stored in this refrigerator. There was a temperature log located on the outside of the refrigerator that revealed documentation of daily temperatures for February with no temperatures outside of the normal parameters. The ADON confirmed 30 degrees was too low and indicated she would address the issue. Unopened insulin should be stored between 36-46 degrees F. Insulin that has been frozen can break down and will be less effective. On 2/14/25 at 12:26 PM observation, with the unit nurse manager (Staff #21), of the second floor medication room's refrigerator revealed a thermometer reading between between 10-20 degrees F. Additionally, a large build up of ice was noted in the upper section of the refrigerator. This refrigerator stored several containers of insulin and an emergency insulin lock box from the pharmacy. The unit nurse manager reported that the temperature is suppose to be 42 degrees and indicated she was going to thaw it out and alert pharmacy. On 2/14/25 at 12:40 PM surveyor informed the Director of Nursing (DON) and Nursing Home Administrator #2 of observation of 1st floor med room fridge at 30 degrees and recent observation of the 2nd floor medication room medication refrigerator with temperature between 10-20 degrees, with a block of ice noted in the upper part of the refrigerator. The DON reported maintenance had recently put in a new thermometer. At 12:47 PM, while at the second floor nursing station, the DON reported they are going to toss the medication. On 2/19/25 at 10:27 AM observation, with Nurse #15, of the second floor medication room refrigerator revealed the block of ice that was observed on 2/14 was noted to be gone, however the thermometer was reading 24 degrees. Nurse #15 confirmed the reading was in the 20s and when asked if this was an acceptable temperature the nurse stated: No, it's not. The nurse went on to report that the top freezer section of the refrigerator is open (door was missing) and it's suppose to be closed. On 2/19/25 at 10:30 AM observation, with Nurse #22, of the first floor medication refrigerator revealed a temperature reading of 35. Nurse #22 first stated the temperature was 41, but after further observation the nurse confirmed the reading was 35. On 2/19/25 at 10:35 AM surveyor informed the DON of this morning's observation of low temperatures in both the first and second floor medication refrigerators. The DON reported they had defrosted the refrigerators last week. The 2nd floor unit manager (Staff #21) was present during this discussion, and reported there was new insulin in the refrigerator and confirmed there was no door on the freezer section of the second floor refrigerator. At 10:52 AM the unit manager (Staff #21) reported maintenance had found the door for the refrigerator. On 2/19/25 at 12:19 PM NHA #2 reported they are moving different refrigerator into the 2nd floor medication room.

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	02/20/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48470 Based on record reviews and interviews, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #1) of 1 resident reviewed for dental services during the survey. The findings include: Resident #1 had been residing in the facility for several years. In an interview with the resident on 2/11/25 at 9:25 AM, s/he reported having mouth pain coming from his/her gums and teeth. The resident also reported that the facility had been informed about this discomfort. A review of Resident #1's medical records on 2/18/25 at 1:43 PM, revealed that the resident was seen by a dentist on 2/2/24 for a periodic examination. A review of the treatment notes by the dentist indicated the examination revealed multiple retained roots, fractured teeth and carries that are non-restorable; patient has history of dental pain, referred to [NAME] Hospital Center where the patient had previous surgical extractions completed; facility notified and assisting patient with appointment. The recommendation to refer the resident to [NAME] hospital for surgical extraction was restated at the bottom left side of the note where it was headlined, Actions Required by Nursing Home Staff. No other documentation was found in Resident #1's medical record to indicate that the resident was sent to [NAME] Hospital Center or other dental institutions. The Director of Nursing (DON) was interviewed on 2/18/25 at 2:04 PM. During the interview, the dental note was reviewed with the DON and was asked if Resident #1 had a more recent dental consultation. The DON reported that she would have to investigate and review the resident's medical records. On 2/19/25 at 9:10 AM, the DON reported that she was still reviewing Resident #1's medical record and had asked the Assistant Director of Nursing (ADON) to help her with the review. The ADON reported on 2/19/25 at 11:30 AM that the resident did not go to [NAME] hospital because his/her insurance did not cover the service. The ADON also confirmed that no other dental consultation had taken place since the resident's dental examination on 2/2/24. The new Nursing Home Administrator (NHA #2) who accompanied the ADON reported that the facility is supposed to look for alternative services when there is a concern with insurance coverage. NHA #2 further reported that the absence of the service or record of the resident getting the extraction meant that the facility was not able to provide that service or assistance to the resident.

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	02/20/2025

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 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. 16218 Based on observation and interview it was determined that the facility failed to have an effective system in place to ensure temperature monitoring of unit refrigerators used to store resident food brought in from outside sources; and facility failed to ensure potentially hazardous food items were cooled according to acceptable standards. This was found to be evident for 3 out of 3 refrigerators observed in resident areas; and during the initial tour of the main kitchen and has the potential to affect all residents. The findings include: 1) Refrigerator temperatures for food storage should be kept at or below 41 degrees Fahrenheit (F). This will ensure food items being stored avoid the Danger Zone (temperatures above 41 degrees and below 135 degrees F) that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. On 2/19/25 at 10:52 AM when asked about storage of resident food brought in from the outside, the 2nd floor unit manager (Staff #21) reported that the activities department has a refrigerator downstairs (on first floor). She went on to state the food would be labled with the resident's name, date and room number. On 2/19/25 at approximately 11:00 AM the Environmental Services Director (ESD) reported that there are resident refrigerators on each floor and proceeded to show the surveyor the location of the first floor refrigerator. Observed of this refrigerator, located in the cafe area near the main entrance, revealed that it had a sign indicating it was for resident food only and that the food should be labeled with name and date; and that the food would be disposed of after 3 days. No temperature log was found to indicate the temperature was being monitored, but there was a thermometer inside the refrigerator that read 45 degrees. Surveyor and ESD also observed three containers of food in this refrigerator but there was no date or label on any of the three items. ESD indicated dietary staff are responsible for monitoring the food items. During this observation the unit nurse manager (Staff #21) arrived to clarify that the activity refrigerator is for snacks. On 2/19/25 at 11:12 AM the ESD and the surveyor observed the resident refrigerator located in the second floor dining room. This fridge had the same sign as the one on the first floor. No temperature log was found to indicate the temperature was being monitored. The thermometer was found inside the refrigerator on the door and the temp read 49 degrees, but this was noted after the door was opened for a few minutes. This fridge contained three bags of food: one bag with a room number only; one bag with room number and name; and one with a room number and a date. (continued on next page)

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	02/20/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/19/25 at 11:17 AM the Food Service Director (FSD Staff #7) reported that after three days they pitch the food. After observation of the items in the second floor resident refrigerator the FSD stated: this is not properly labeled; I was here two days ago and cleared it out. The FSD reported she checks the temperature of the refrigerator on the second floor but confirmed no written log was kept. The FSD also reported the nurses check the temperature of the refrigerator downstairs and that activities is responsible for monitoring the refrigerator in their area. Surveyor informed the FSD of the observation of the thermometer reading 49 degrees, the FSD changed to location of the thermometer. On 02/19/25 at 11:47 AM interview with the activity aide (Staff #27) reported that he sometimes stores resident's food in the activity refrigerator. After observation of the inside of the activity refrigerator the activity aide #27 confirmed there was no thermometer inside the refrigerator. Surveyor observed a bag labeled with a resident's name (Resident #7) and a date; and several bulk items that the activity aide #27 reported were for baking activities. The bulk items in the refrigerator failed to have labels to indicate what they were, instruction for storage or cooking, or expiration dates. On 2/19/25 at 11:54 AM the FSD reported she has now added a temperature log to the first floor resident refrigerator and indicated she would be responsible for monitoring. On 2/19/25 at 12:00 PM surveyor reveiwed the concerns with the NHA #2 regarding the unlabled food items in the resident refrigerators and the failure to monitor the temperature of the resident and activity refrigerators. Surveyor also reviewed the concern of no thermometer in the activity fridge. At 12:05 PM the NHA #2 confirmed there was no thermometer in the Activity refrigerator. At 12:19 PM the NHA #2 reported the activity fridge does read the temperature on the display panel but confirmed the temperature was not being monitored. She reported the activity refrigerator has been cleared out. 48470 2) An inspection of the stand-up refrigerator was conducted with the Food Service Director (FSD Staff #7) on 2/10/25 at 9:58 AM. During the inspection, a number of cooked food items were observed. These food items include: a) Oatmeal dated 2/9/25 b) pureed bread dated 2/10/25 c) grits dated 2/10/25 d) beef stock dated 2/9/25 e) gravy dated 2/7/25 f) pureed vegetable dated 2/9/25 g) ground chicken dated 2/10/25 (continued on next page)

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	02/20/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FSD #7 reported that the ground chicken was cooked about two hours ago. The FSD #7 was interviewed about the facility's cool down process and where documentations are kept for the cool down logs. The FSD #7 reported that they don't have a cool down process and that they don't monitor temperatures of cooked potentially hazardous food items when cooling them down. The FSD #7 stated, we just had a sanitary inspection done about a month ago and there were no concerns. The FSD #7 also reported that she knew about the regulation of monitoring the temperature for the cool down process for potentially hazardous food items but was under the impression that she was not required to do it in the facility. Later that day, at 10:40 AM, FSD #7 printed and provided the surveyor a copy of a document titled Cooling log and stated, we will start doing them now. FSD #7 reported that she had educated the cooks on how to use the cooling log and that all the cooked items observed earlier would be discarded. On 2/19/25 at 2:43 PM, the concern was discussed with the Director of Nursing (DON) that the facility did not have a process to monitor temperatures of cooked potentially hazardous food items when being cooled down. The DON verbalized understanding and acknowledged the concern.

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	02/20/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48168 Based on record review and interviews, it was determined that the facility failed to accurately assess the resident population's needs. This was evident during a review of the Facility Assessment during the recertification survey. The findings include: On 2/10/25, during the entrance conference, the Nursing Home Administrator (NHA #1) was asked to provide a copy of the Facility Assessment. On 2/14/25 at 8:20 AM a review of the Facility Assessment revealed that on page 2 there was a list titled Acuity which listed Special Treatments. Ostomy Care was listed but indicated N/A [not applicable] for Number/Average or Range of Residents, that needed that type of care. A review of the facility matrix revealed one resident who required ostomy care. On 2/14/25 at 9:38 AM an interview was conducted with NHA #1 regarding the facility assessment. He said that N/A listed on the list of Special Treatments indicated that the facility did not care for residents with those medical needs. The NHA was asked to review the entry which stated N/A for ostomy care, the NHA said it was incorrect, that there were residents who needed that type of care in the facility. He further stated that the assessment was done in April 2024 and needed to be updated. On 2/14/25 at 9:46 AM an interview was conducted with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the unit manager for the second floor (Staff #21) in the ADON's office. When asked about the Facility Assessment, the DON said that the assessment had been updated since April 2024 - that she and the former NHA (Staff #17) worked on it and that NHA started in April 2024 and left in November 2024. The DON said she would provide an updated copy of the Facility Assessment. On 2/18/25 at 11:28 AM the DON was asked again for an updated copy of the facility assessment. The DON said that the regional staff had it and would print it and the DON would provide a copy of it to the survey team. On 2/18/25 at 3:10 PM the DON was asked again to provide the updated Facility Assessment. She said she did not have it yet. On 2/18/25 at 4:07 PM the DON was asked again for the updated Facility Assessment. The DON said she did not have a copy of the updated/corrected facility assessment to provide to the survey team.

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	02/20/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48168 Based on observation, interviews and medical record reviews it was determined that the facility failed to safeguard resident's confidential medical records; failed to ensure medical records are kept accurate and current; and failed to ensure documentation of the certification of medical ineffectiveness before changing a resident's code status from a full code to Do Not Resuscitate (DNR). This was evident for 4 (Resident #55, #51, # 16 and #66) out of 42 residents reviewed during the survey. The findings include: 1)On [DATE] at 11:14 AM an observation of medication administration for Resident #55 was conducted. The facility Certified Medicine Aide (CMA #12) was observed at the medication cart in the hallway outside the resident's room. On [DATE] at 11:15 AM CMA #12 removed 2 bottles of stock medications, viewed the computer screen on top of the medication cart, which was open to Resident #55's clinical information, returned the bottles to the drawer, said that she needed to go get something, and she walked away from the cart. On [DATE] at 11:17 AM an interview was conducted with the unit manager (Staff #21) who was in the hallway a few feet away from the medication cart. The unit manager #21 was asked to verify if Resident #55's confidential medical information was visible on the computer on top of the medication cart. The unit manager #21 confirmed that the resident's information was visible and said that when the CMA walked away from the medication cart, she should have closed the screen with the resident's information on it and secured access to the computer. On [DATE] at 11:19 AM CMA #12 returned to the medication cart and the unit manager #21 confirmed with the CMA that she had left Resident #55's clinical information visible and that she did not secure access to the computer. On [DATE] at 2:50 PM an interview with the Director of Nursing (DON) was conducted to review the finding that CMA #12 left an Resident #55's medical records unsecured. The DON said she had been informed of the deficiency, and she provided no other information. On [DATE] at 3:35 PM an interview with the Nursing Home Administrator (NHA #1) was conducted to review the survey deficiencies. He provided no additional information. 48470 2) A Medical Orders for Life Sustaining Treatment or MOLST form contains medical orders regarding life-sustaining treatments, the use of medical tests, whether to transfer a patient to a hospital and any other matter considered appropriate by the Department to implement the treatment preferences of patients. A MOLST form is not an advanced directive. A MOLST form contains written medical orders related to a patient's medical condition. (continued on next page)

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	02/20/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #51 was admitted to the facility in mid-2023. A review of the resident's electronic health record (EHR) on [DATE] at 3:17 PM revealed 2 active MOLST forms. One MOLST was signed on [DATE], that ordered the resident to be a full code per the resident's surrogate; the other MOLST was signed on [DATE], that ordered for the resident to be a Do Not Resuscitate (DNR)/ Do not Intubate (DNI) per the resident's surrogate. A subsequent review of Resident #51's EHR on [DATE] at 9:26 AM, revealed an order that indicated the resident's code status as DNI/DNR. The Licensed Practical Nurse (LPN #22) who was currently assigned to Resident #51, was interviewed on [DATE] at 9:54 AM. During the interview, LPN #22 reported her process when a resident's heart would stop. LPN #22 indicated that a resident's code status can be seen right away on their profile page in the EHR. LPN #22 was asked to check the code status of Resident #51. She reported that the resident was a DNR/DNI as seen in the resident's profile. LPN #22 was then asked how the information can be verified, and she reported that she would review the MOLST. LPN #22 then proceeded to look up Resident #51's MOLST in the EHR and reported that the resident was a full code. LPN #22 was referring to the MOLST signed on [DATE]. Because of the discrepancy on the reported code status of Resident #51, LPN #22 was specifically asked on [DATE] at 10:01 AM, if the resident's heart stopped right now, what would you do? LPN #22 looked in her computer briefly and stated, I would do Cardiopulmonary resuscitation (CPR) and indicated that the resident's code status needed to be updated. On [DATE] at 10:16 AM, Resident #51's hard chart was reviewed and revealed the 2 MOLST forms. The MOLST signed on [DATE] was on the front and directly behind it was the other, that was signed on [DATE] with VOID written over it. An interview was conducted with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the incoming Nursing Home Administrator (NHA#2) on [DATE] at 10:38 AM. The concern was discussed that after reviewing Resident #51's EHR, LPN #22 would perform CPR as stated in an earlier interview. The DON reported that a resident's code status would always be verified by reviewing the MOLST on the hard chart. The DON also reported that the facility had already identified concerns with records not matching between the hard chart and EHR in a meeting conducted about 2 weeks ago. The DON indicated that the Social Worker had started an audit to fix the concern. The concern was reviewed with all 3 staff (ADON, DON, and NHA #2) that Resident #51's EHR had 2 active MOLST forms. The process of correctly voiding a MOLST form was also discussed. All 3 staff verbalized understanding and acknowledged the concern. 3) Resident #16 had been residing in the facility since 2019. A review of the resident's record on [DATE] at 11 AM, revealed a progress note with an effective date of [DATE] at 5:47 PM that indicated the resident was positive with an influenza infection. The next progress note with an effective date of [DATE] at 6:52, indicated that the resident tested positive for Respiratory Syncytial Virus (RSV). (continued on next page)

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	02/20/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #16's lab test result was reviewed on [DATE] at 11:22 AM. The review revealed that the resident was positive for influenza A, but negative for RSV. The Assistant Director of Nursing (ADON) was interviewed on [DATE] at 11:46 AM. During the interview, she reported the facility's process with transmission-based precautions and that she kept tracking documentation of all the residents with respiratory infections. On [DATE] at 11:56 AM, the ADON confirmed that Resident #16 was positive for influenza A only. The progress note with an effective date of [DATE] at 6:52 was reviewed with ADON and she reported that the documentation was done in error. On [DATE] at 2:43 PM, the concern of inaccurate resident record was discussed with the Director of Nursing, and she acknowledged the concern. 51900 4) On [DATE] review of Resident #66 ' s medical record revealed the resident had orders for a full code until a new Maryland Orders for Life-Sustaining Treatment (MOLST) was completed on [DATE]. Full code means that if cardiac or pulmonary arrest occurs the staff should attempt cardiopulmonary resuscitation (CPR). This includes any medical efforts indicated during arrest, including artificial ventilation and efforts to restore and stabilize cardiopulmonary function. On [DATE] further review of the medical record failed to reveal documentation to indicate the resident had an Advance Directive or had appointed a Health Care Power of Attorney. The resident was deemed incapable of making health care decisions by at least one physician. Review of the new MOLST, dated [DATE], revealed it was discussed with the patient's surrogate per the authority granted by the Health Care Decisions Act (HCDA) and included orders for the resident to be DNR (Do Not Resuscitate). DNR means that before cardiac or respiratory arrest staff is to administer all medications needed to stabilize the patient, but if arrest occurs, they should not attempt to perform CPR and allow death to occur naturally. According to the HCDA, a resident ' s code status can be changed by a surrogate decision maker to a DNR if two physicians have certified that a patient is in a terminal condition, end-stage condition, or persistent vegetative state or if the criteria for medical ineffectiveness set forth in the Health Care Decisions Act are met, then the attending physician and a second physician may certify that the treatment is medically ineffective. Medically ineffective treatment means that, to a reasonable degree of medical certainty, a medical procedure will not prevent or reduce the deterioration of the health of an individual; or prevent the impending death of an individual. On [DATE] further review of the medical record failed to reveal documentation to certify that the resident met the conditions required by the HCDA prior to changing the resident ' s code status to DNR. (continued on next page)

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	02/20/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 12 noon an interview was conducted with the Director of Nursing and the Social Service Director (SSD - Staff #13) regarding the resident ' s decision-making capacity and code status. The SSD confirmed the resident did not have an Advance Directive and that the family member was in the process of pursuing guardianship. Surveyor reviewed the concern that documentation was found that only one physician had certified the resident was not capable of making decisions and no documentation was found to indicate that there was a certification of general status or medical ineffectiveness completed prior to changing the resident ' s code status. On [DATE] at 2:00 PM the DON provided the surveyor with two Physician Certifications Related to Medical Condition, Decision Making, and Treatment Limitations, dated [DATE] and [DATE]. Review of these documents revealed the physicians had certified that CPR would be medically ineffective. On [DATE] at approximately 2:20 PM surveyor reviewed the concern with the DON regarding the failure to ensure the certifications of medical ineffectiveness were completed prior to changing the resident ' s code status from full code to DNR.

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	02/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 51900 Based on observation, interviews, and review of medical records and facility policy and procedures it was determined that the facility failed to follow enhanced barrier precautions and perform hand hygiene when indicated; and failed to ensure linens were processed so as to prevent the spread of infection. This was found to be evident for 2 (Resident #19 and #66) out of 24 residents observed during the initial phase of the survey but has the potential to affect all residents. The findings include: 1a)Resident #19 has a care plan, initiated in April 2024, addressing the risk of infection due to the use of a feeding tube. The interventions include: Enhanced Barrier Precautions when providing resident care secondary to the use of a feeding tube. Enhanced barrier precautions (EBP) are a set of infection control practices that use gowns and gloves to reduce the spread of infections. A gastrostomy tube (G-tube), also known as a feeding tube, is a surgically placed device used to give direct access to a person's stomach for feeding, hydration, or medicine. On 2/10/25 at 11:23 AM surveyor knocked on Resident #19's door. The door was answered by the geriatric nursing assistant (GNA-Staff #18) who indicated she was currently performing care for the resident. Surveyor noted that the GNA was not wearing a gown at this time. Surveyor waited in the hallway until the staff came out of the room. The GNA reported she had given the resident a bed bath and confirmed she did not put on a gown while providing care. When asked if she was supposed to wear a gown when providing care for this resident, GNA #18 responded: yes, I forgot. The Director of Nursing was made aware of this observation on 2/19/25 at 3:40 PM. 1b) During an observation of Nurse (Staff #14) on 02/13/25 at 10:10 AM two surveyors witnessed nurse #14 remove Resident #66's G-tube feeding tubing from the residents G-tube without performing hand hygiene immediately prior to touching the tube, and did not DON gloves or a gown. Review of Resident #66 medical record revealed the resident was on enhanced barrier precautions. Review of the facility's Enhanced Barrier Precautions Policy and Procedure indicates that Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Review of the facility's Standard Precautions Policy and Procedure states that Hand Hygiene is to be performed before and after contact with a resident, before performing an aseptic (a set of practices that prevent the spread of infection) task, after contact with items in a resident's room, and after removing gloves. (continued on next page)

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	02/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/13/25 around 12:30 PM the surveyors informed the Director of Nursing and the Assistant Director of Nursing that nurse #14 was observed removing G-tube tubing without performing hand hygiene or wearing a gown or gloves. 2) On 2/13/25 at 3:40 PM, the surveyor observed the laundry room and interviewed Staff # 19. The surveyor observed that to the left of the door, there was a linen bin with a closed lid, two washing machines and two dryers in the center of the room- side by side, a table to the right of the room with two levels that held clean linen and a covered linen cart to the right of the table. The surveyor asked Staff #19 to explain the process of handling the laundry. He stated that dirty linen is sorted upstairs and then brought to the bin to the left of the washers, which is designated as the dirty linen area. The dirty clothes and linens are brought to the laundry room already sorted and in plastic bags. Further, he stated that residents' clothes and linens are washed separately from the other laundry. On 02/14/25 at 8:26 AM the surveyor interviewed Staff #20 in laundry services. The surveyor had noticed a container, without a lid, that held wet linens piled above the top of the container that was placed in front of the dryers and asked what it was. Staff #20 stated that it was clean laundry waiting to be put in the dryer. This container was approximately two feet from the dirty laundry bin and no can liner was noted to be in the clean laundry can. There was no writing on the container to indicate that this was a designated clean linen container. The surveyor asked Staff #20 how he processes laundry, and he stated that he separates the laundry in the laundry room to the left of the clean area. He explained that the nurses usually separate the clothing from linens and bag it up before sending it to the laundry. He then lifted the lid off the designated dirty laundry bin and the surveyor observed that there were loose linens unbagged mixed with bagged linens and clothes. Staff #20 then closed the lid and stated again that they are usually bagged before coming to the laundry room. The Surveyor observed that Staff #20 was not wearing any Personal Protective Equipment (PPE), such as a gown or gloves, and asked what the expectation is for staff and the use of PPE in the laundry facilities. Staff #20 stated that he doesn't wear a gown between handling clean and dirty laundry but that instead he takes off his top shirt (he was wearing two layers, a long sleeve shirt with a short-sleeved shirt underneath) when handling clean laundry. The surveyor interviewed the Environmental Services Director (ESD) on 02/14/25 at 9:35 AM, who stated that there was a waiver on file due to not having a physical barrier between the clean and dirty areas of the laundry room. The surveyor asked what the process is for handling dirty and clean linens and what the expectation is about wearing PPE while handling laundry. She explained that when processing dirty laundry, isolation gowns, gloves, and masks are to be worn, that laundry is presorted on the units in designated linen closets, and that the dirty laundry arrives pre-sorted and bagged. The Surveyor notified the ESD that Staff #20 stated that he changes his shirt instead of using a gown. She confirmed that she had just seen him in the hall in his t-shirt and re-educated him about the use of PPE. (continued on next page)

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	02/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor then asked about the container that was being used to hold clean linens and informed her that the container had been observed as overflowing, without a lid, and was not marked as clean linen. She stated that there should have been a lid that designated that container as clean laundry. When asked if there is an official onboarding or annual training for Environmental Services Employees, she stated that while there is no official education, she tries to tell them everything within a few days of hire. A review of the facility policy and procedure titled Departmental (Environmental Services)- Laundry and Linen States the following: Separate soiled and clean linen at all times; Employees sorting or washing linen must wear a gown and gloves and must wear heavy-duty rubber gloves for sorting laundry; Clean linen will remain hygienically clean through measures designed to protect it from environmental contamination, such as covering clean linen cart.

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	02/20/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 51900 Based on staff and resident medical record review and interviews, it was determined that the facility failed to provide education and offer staff and residents the current COVID-19 vaccination. This was evident in four (Staff #28, #29, #30, and #31) out of four staff and two (Resident #66 and #48) out of five residents reviewed for immunization status. The findings include: On 2/13/25 at 12:00 PM the surveyor asked the Director of Nursing (DON) for Staff #28, #29, #30, and #31's employee health files to review. On 2/14/25 at approximately 1:00 PM the surveyor reviewed medical records for resident immunizations and noted no record of Resident #66 or #48 being offered or educated about the current COVID-19 immunization. The surveyor also reviewed four (Staff #28, #29, #30, #31) employee health files and could not find proof of current COVID-19 immunization acceptance, refusal, or education. On 2/14/25 at approximately 1:15 PM the surveyor notified the Assistant Director of Nursing (ADON) that the surveyor was unable to find records of current COVID-19 education or immunization for Staff #28, #29, #30, and #31 or for Residents #48 and #66, and offered her the opportunity to provide any records that would provide proof of compliance. On 2/18/25 at 11:27 AM the DON came to the surveyor to ask if there were any outstanding items needed. The survey again asked for proof of COVID-19 immunizations, refusals, and education. On 2/19/25 at 11:26 AM the ADON provided immunization records for Staff #28, #29, #30, and #31, which were the same records that were previously received. They did not have the updated COVID-19 information, and she didn't provide an update for Resident #66 or #48. The surveyor explained to the ADON that no documentation has been provided to show proof of current COVID-19, declination, or education for Staff #28, #29, #30, and #31 and Residents #48 and #66. The ADON said she would go look again for the records. At the time of survey exit on 2/19/25 at 4:00 PM no additional documentation was provided regarding this concern.

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	02/20/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48470 Based on observations and interviews, it was determined that the facility failed to ensure the walk-in freezer was kept in a safe operating condition. This was evident for 1 out of 1 walk in freezer in the kitchen. The findings include: A tour of the kitchen was conducted with the Food Service Director (FSD Staff #7) on 2/10/25 at 9:49 AM. During the tour, an inspection of the walk-in freezer was completed, and frost was observed that had built up around the door. It was also observed that it would not close and latch on its own. When the surveyor attempted to close the freezer door, a significant amount of force was applied to make it latch. The FSD stated, we are supposed to have a renovation soon and indicated that the facility was old. On 2/19/25 at 2:43 PM, the concern was discussed with the Director of Nursing (DON) that the walk-in freezer was not kept in a safe operating condition. The observation of frost build-up and the freezer door unable to latch and close on its own was discussed. The DON acknowledged the concern.