STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure staff reported allegations of abuse within the required two-hour timeframe. The deficiency affected 2 (Resident #2 and Resident #6) of 6 residents reviewed for abuse or neglect.Findings included:A facility policy titled, Abuse/Neglect/Misappropriation/Crime, Reporting Requirements/Investigations, dated 02/05/2023, indicated, 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegations do not involve abuse and do not result in serious bodily injury.1. An admission Record revealed the facility admitted Resident #2 on 09/18/2025. According to the admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, bipolar disorder, and dementia with other behavioral disturbance.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #2's Care Plan included a focus area, initiated 09/19/2025, that indicated behaviors related to bipolar, depressive, and anxiety disorders causing them to be making multiple self-calling 911 calls, fabricating allegations, and crawling on the floor. Interventions directed staff to provide 1:1 activity as needed, to assign staff members that are familiar or preferred by the resident when possible, and to assure the resident they are safe if they become distressed. A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 09/23/2025, revealed that at approximately 1:30 AM, emergency medical services (EMS) and police arrived at the facility after Resident #2 called 911 and alleged that Geriatric Nursing Assistant (GNA) #2 hit them with a metal rod. Per the initial report, the Director of Nursing (DON) notified the Administrator of the allegation at 9:00 AM on 09/23/2025 and the initial report was submitted to the state survey agency on 09/23/2025 at 4:00 PM.An email to the DON, dated 09/23/2025 at 4:09 PM, revealed confirmation that the state survey agency had received the initial report.During an interview on 10/06/2025 at 1:01 PM, Resident #2 stated that a GNA came to change their incontinence brief and hit them with a call light on their hip. Resident #2 further stated they made a police report related to the incident. During an interview on 10/07/2025 at 4:40 PM, GNA #2 stated that GNA #18 assisted her with changing Resident #2's incontinence brief and the resident accepted the brief change without incident. GNA #2 stated that approximately 30 minutes after changing Resident #2's incontinence brief, police and EMS arrived. She stated staff were surprised because they did not know Resident #2 called 911. GNA #2 stated that Resident #2 told the first responders she (GNA #2) hit the resident with a metal rod. GNA #2 stated that she did not hit the resident.During an interview on 10/08/2025 at 2:53 PM, GNA #2 stated she did not report Resident #2's allegation of abuse because the supervisor was there when the allegation was made.During an interview on 10/07/2025 at 4:57 PM, GNA #18 stated GNA #2 asked her to help change Resident #2's incontinence brief, and they did so without incident. GNA #18 further stated police arrived at the facility after Resident #2 called 911 without staff knowledge. Per GNA #18, the police stated Resident #2 alleged GNA #2 hit them in the head with a metal rod. During an interview on 10/08/2025 at 12:58 PM, GNA #18 stated she did not report the physical abuse allegation to the Abuse Coordinator because no abuse occurred at 1:00 AM during incontinence care. During an interview on 10/09/2025 at 1:35 PM, Registered Nurse (RN) #20 stated the police notified her that Resident #2 alleged GNA #2, hit them with a metal rod. RN #20 then stated she called RN Unit Manager #19 to notify them of the allegation of abuse and that Resident #2 was being transported to the hospital for evaluation. RN #20 then stated she did not know when the DON notified the Administrator of the physical abuse allegation. During an interview on 10/08/2025 at 8:06 AM, RN Unit Manager #19 stated she did not learn of Resident #2's physical abuse allegation until after the fact. During an interview on 10/09/2025 at 12:39 PM, the DON stated that at around 1:00 AM, Resident #2 called 911 and alleged GNA #2 hit them with a metal rod. The DON further stated she was aware the allegation of physical abuse was not reported within the required two-hour timeframe.During an interview on 10/09/2025 at 2:01 PM, the Assistant Administrator stated Resident #2 made an allegation of staff-to-resident abuse at 1:30 AM on 09/23/2025, and the DON notified the Administrator at 9:00 AM on 09/23/2025. The Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, facility document review, and interview, the facility failed to immediately implement interventions to protect residents during an investigation following an allegation of abuse, which affected 1 (Resident #2) of 6 residents reviewed for abuse or neglect. Specifically, Resident #2 alleged Geriatric Nursing Assistant (GNA) #2 hit them with a metal rod. GNA #2 completed their scheduled shift rather than being immediately suspended to protect residents from further potential abuse or neglect while the facility conducted an investigation. Findings included:A facility policy titled, Abuse/Neglect/Misappropriation/Crime, Patient Protection, dated 10/17/2023, indicated, There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the [facility's name]. The policy revealed, Any employee and/or covered agent of the Center, who willfully abuses including abuse facilitated or enabled through the use of technology, neglects, robs, exploits, or commits any crime, or participates in any criminal activity against any patient of the Center will be immediately subjected to corrective action, suspension, and/or termination as necessary.An admission Record revealed the facility admitted Resident #2 on 09/18/2025. According to the admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, bipolar disorder, and dementia with other behavioral disturbance.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #2's Care Plan included a focus area, initiated 09/19/2025, that indicated behaviors related to bipolar, depressive, and anxiety disorders causing them to be making multiple self-calling 911 calls, fabricating allegations, and crawling on the floor. Interventions directed staff to provide 1:1 activity as needed, to assign staff members that are familiar or preferred by the resident when possible, and to assure the resident they are safe if they become distressed. A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form dated 09/23/2025, and a Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form dated 09/30/2025, revealed that at approximately 1:30 AM, emergency medical services (EMS) and police arrived at the facility after Resident #2 called 911 and alleged that GNA #2 hit them with a metal rod. The documents indicated that GNA #2 was suspended, pending investigation but did not indicate a time or date the suspension took effect. During an interview on 10/06/2025 at 1:01 PM, Resident #2 stated that a GNA came to change their incontinence brief and hit them with a call light on their hip. Resident #2 further stated they made a police report related to the incident. During an interview on 10/07/2025 at 4:57 PM, GNA #18 stated GNA #2 asked her to help change Resident #2's incontinence brief, and they did so without incident. GNA #18 further stated police arrived at the facility after Resident #2 called 911 without staff knowledge. Per GNA #18, the police stated Resident #2 alleged GNA #2 hit them in the head with a metal rod. During an interview on 10/07/2025 at 4:40 PM, GNA #2 stated that GNA #18 assisted her with changing Resident #2's incontinence brief and the resident accepted the brief change without incident. GNA #2 stated that approximately 30 minutes after changing Resident #2's incontinence brief, police and EMS arrived. She stated staff were surprised because they did not know Resident #2 called 911. GNA #2 stated that Resident #2 told the first responders she (GNA #2) hit the resident with a metal rod. GNA #2 stated that she did not hit the resident. GNA #2 stated the facility suspended her for a day, following the allegation, while the facility investigated the allegation.GNA #2's Employee Punch Report revealed GNA #2 worked from 10:59 PM on 09/22/2025 until 7:04 AM on 09/23/2025.During an interview on 10/10/2025 at 11:40 AM, the Director of Nursing (DON) stated GNA #2 completed their shift at 7:00 AM, after Resident #2 made the abuse allegation. The DON further stated GNA #2 should have been sent home immediately after Resident #2 made the abuse allegation. The DON stated it was an oversight on management's part. During an interview on 10/10/2025 at 11:53 AM, the Administrator stated GNA #2 was suspended pending investigation, but she should have been sent home immediately once the allegation was made instead of staying until she completed her shift at 7:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potomac Valley Rehabilitation and Healthcare	1235 Potomac Valley Road Rockville, MD 20850

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, facility document review, and interview, the facility failed to provide medication as ordered by the physician in a timely manner for 1 (Resident #7) of 6 residents reviewed for abuse or neglect. Specifically, Resident #7's methylprednisolone (a corticosteroid to prevent inflammation) that was ordered on 04/25/2025 was not delivered to the facility until 04/29/2025 and the resident did not receive it until 04/30/2025.Findings included:A facility policy titled, Ordering and Receiving Non-Controlled Medications, dated 09/2018, indicated, Medications and related products are received from the pharmacy on a timely basis. The policy also indicated, I. Ordering Medications from the Pharmacy included, 5. When calling/faxing/sending electronic medication orders for a newly (re)admitted resident, the pharmacy is also given all allergies and diagnoses to facilitate generation of a patient profile and permit initial medication use assessment. Per the policy, II. Receiving Medications for the Pharmacy specified, 1. When receiving medications from the pharmacy, a licensed nurse, which included a. Receives medications delivered to the facility and documents that the delivery was received and was secure on the medication delivery receipt; b. Verifies medications received and directions for use with the medication order form; and c. Reports discrepancies and omissions to the pharmacy within 24 hours from delivery. Nurse shall also notify charge nurse/supervisor or in accordance with facility policy. An admission Record revealed the facility admitted Resident #7 on 04/25/2025. According to the admission Record, the resident had a medical history that included diagnoses of rheumatoid arthritis and an unspecified disorder of the adrenal gland. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #7 admitted from a short-term stay at a general hospital. Resident #7's Care Plan Report included a focus area created 04/27/2025, that indicated the resident had Addison's disease (a disease of insufficient hormone production) with adrenal suppression and was at risk for complications. Interventions directed staff to administer medications as ordered (created 04/27/2025). Resident #7's hospital Discharge Summary, dated 04/25/2025, indicated the resident was to be administered a methylprednisolone taper as an outpatient. Resident #7's Order Recap [Recapitulation] Report, with orders from 04/01/2025 through 10/31/2025, included an order, dated 04/25/2025, for methylprednisolone 4 milligrams (mg) with instructions to give six tablets by mouth one time a day until 04/29/2025; five tablets by mouth one time a day until 05/04/2025; four tablets by mouth one time a day until 05/09/2025; three tablets by mouth one time a day until 05/14/2025; two tablets by mouth one time a day until 05/19/2025; and one tablet by mouth one time a day for five days for Addison's disease.Resident #7's April 2025 Medication Administration Record [MAR], revealed that staff documented a 9 on the MAR from 04/26/2025 through 04/29/2025 for methylprednisolone, which indicated Other/See Progress Notes. The MAR revealed Resident #7 received their first dose of methylprednisolone on 04/30/2025. Resident #7's Progress Notes revealed an Administration Note, dated 04/26/2025 at 8:58 AM, that revealed methylprednisolone had not been delivered. Resident #7's Progress Notes revealed an Administration Note, dated 04/27/2025 at 7:18 AM, that revealed methylprednisolone was on order.Resident #7's Progress Notes revealed an Administration Note, dated 04/28/2025 at 6:03 AM, that revealed methylprednisolone had not been delivered.Resident #7's Progress Notes revealed a Medication Visit note, dated 04/28/2025 at 4:04 PM, that indicated the resident had a history of Addison's disease, was treated with methylprednisolone while at the hospital for possible adrenal crisis, and was discharged from the hospital on a tapering dose of methylprednisolone. The note indicated that the resident reported they were not receiving the medication. The note indicated the provider reviewed the record and determined the medication was not yet delivered per pharmacy.Resident #7's Progress Notes revealed a Health Status Note, dated 04/28/2025 at 4:17 PM, that revealed the pharmacy was called about the methylprednisolone, the pharmacy stated the medication would be delivered on the second delivery, and the resident and nurse practitioner were made aware. Resident #7's Progress Notes revealed an Administration Note dated 04/29/2025 at 5:17 AM, that revealed the methylprednisolone was on order. A facility document titled, Delivery Manifest, dated 04/29/2025 at 6:57 PM, revealed 81 methylprednisolone 4 mg tablets were delivered for Resident #7. The resident's April 2025 Medication Administration Record indicated that staff documented the resident received their first dose of the medication on 04/30/2025During an interview on 10/09/2025 at 2:01 PM, Certified Registered Nurse Practitioner (CRNP) #25 stated Resident #7 complained they were not getting their medication. CRNP #25 stated the pharmacy would not send it