

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Potomac Valley Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview it was determined the facility failed to ensure a homelike environment, This was evident during multiple observations by the surveyor for 1 (Unit D) out of 4 nursing units and during the surveyor's review of the environment task during the facility's recertification survey. The findings include: On 6/1/26 at 7:49AM during the surveyor's initial tour of the facility the air vent located in the main lobby was observed with thick dark grey debris present on it. On 6/1/26 at 9:45AM the surveyor observed the nursing Unit D carpeting present within the main hallways of the unit to be in severely worn condition with various staining throughout. On 6/2/26 at 11:47AM the surveyor observed an exterior vent with extensive yellow and green debris present on it on the front side of the facility adjacent to the driveway. On 6/2/26 at 11:48AM the surveyor observed a crack in the Unit D nursing wing window glass pane located in the main dining area which extended several feet in length. On 6/2/26 at 11:51AM the surveyor observed a large depressed and cracked area in the facility's parking lot with mud present within it located across from the Resident smoking area. On 6/3/26 at 8:32AM the surveyor observed Resident #127's bedroom furniture with worn areas of unfinished appearing surface material. On 6/3/26 at 8:35AM the surveyor observed Resident room signage throughout the nursing unit D hallway at which time multiple signage was observed in disrepair. Cracks were observed to be present in various room signage, and tape was observed present affixing 104B's name to the signage. Resident room doors throughout the nursing Unit D hallway were observed by the surveyor to have various chipping and scraping present. On 6/3/26 at 8:38AM the surveyor observed 2 of 4 circular ceiling lights located above the Unit D nurse station which were unfinished in appearance with observable chipped drywall surrounding them. On 6/8/26 at 12:06PM the surveyor conducted an interview of and shared concerns with Maintenance Director #16 who acknowledged the concerns. Regarding the parking lot condition, Maintenance Director #16 reported the facility was in the process of continuing to get proposal estimates for repair of the damaged area. During surveyor initiated dual observation of all concerns with Maintenance Director #16 on nursing Unit D on 6/8/26 at 12:13PM, various Resident room furniture was observed from the hallway of the D wing nursing unit with severely worn and stained appearance. The bird enclosure located in the main area of Unit D was additionally observed with unclean creamy debris present on the surface of the glass. Maintenance Director #16 observed and acknowledged the surveyor's concerns. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. Regarding the condition of the carpeting, the Administrator communicated to the survey team that a corporate approval for carpeting replacement was necessary, and reported that quotes were being obtained for the damaged parking lot area.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215026 If continuation sheet Page 1 of 33

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to: 1.) Ensure the kitchen environment surfaces was maintained free from dust/debris, 2.) Ensure a light switch plate was maintained, 3.) Ensure cleaned dishes were stored in an area free from potential for contamination by dust/debris/chipping paint, 4.) Ensure the freezer was maintained free from accumulation of ice build up, and 5.) Follow professional standards for foods stored in refrigeration units. This was evident for 1 out of 1 facility kitchen during the surveyor's review of the kitchen task during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility's kitchen on 6/1/26 at 7:58AM a light switch plate located above the handwashing sink was observed with rust colored areas. On 6/1/26 at 8:00AM the surveyor observed various kitchen walls, ceiling areas, and piping within the kitchen with grey debris present on the surfaces. On 6/1/26 at 8:00AM the surveyor observed the walk in refrigerator and noted that the area within the walk in refrigerator surrounding the freezer door had accumulation of frosty ice build up present. On 6/1/26 at 8:01AM the surveyor conducted an observation of the facility's walk in freezer and noted frosty ice build up was present on the freezer fan and adjacent to the freezer fan. Boxes of food were observed tightly packed within the freezer space including stored within and on the walking aisle. On 6/1/26 at 8:06AM the surveyor conducted a dual observation of the concerns with Dietary Director #23 who observed and acknowledged the surveyor's concerns. At this time the surveyor conducted an interview of Dietary Director #23 who reported they had been in their role for about one year and that the ice build up issue had been going on for awhile because the seal is broken. On 6/1/26 at 8:10AM the surveyor observed a running electric fan covered with grey dusty debris pointed on the clean dish conveyor area which was holding food trays and cookware. Upon further observation of the fan area, the surveyor noted that where the fan attached to the wall, grey dusty debris was noted and areas of cracking wall paint were observed on the ceiling above the fan. A thick layer of chemical appearing debris was noted to be present on dishwasher piping and top surface of the dishwasher. On 6/1/26 at 8:23AM the surveyor shared all concerns and dually observed the concerns with Dietary Director #23 who acknowledged and confirmed understanding of the concerns. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined that the facility failed to ensure that the residents' call system was functioning properly. This was found to be evident for 2 resident rooms (room [ROOM NUMBER] and #102) on Unit B during the annual recertification survey. This finding had the potential to affect all residents Unit B. The findings include: On 6/1/2026 at 1:40PM, Resident #159 reported pressing the call bell in the morning with no assistance until his/her lunch was delivered. At 1:50PM, the resident pressed the call bell. The Surveyor observed the light illuminated outside the resident's door. At the nurses' station, there was no alarm heard and no visual notification to indicate a resident pressed the call bell and which room needed assistance. On 6/1/2026 at 1:52PM, during an observation at the B wing nurses' station with the Nursing Home Administrator (NHA), the Surveyor confirmed that there was no alarm heard from room [ROOM NUMBER] and no indication the resident pressed the call button. The NHA administrator tested the call bell in room [ROOM NUMBER]. The light illuminated outside the room; however, at the nurses' station, the alarm failed to alert and there was no indication a resident pressed the call bell for assistance. The NHA noted that although technicians worked on the monitor on 5/29/2026 and were awaiting a part, the audible alarm should have remained functional. The Surveyor expressed the concern that Resident #159 stated that he/she pressed the call bell, and no one responded for hours and the call system at the B wing nurses' unit was not functioning properly. The NHA stated that maintenance staff will inspect the call system. On 6/1/2026 at 2:18PM the NHA, in the presence of the Director of Nursing (DON), informed the Surveyor that the maintenance staff repaired the alarm issue at B wing nurses' station.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review it was determined the facility failed to ensure maintenance of dignity and provide for self determination for Residents. This was evident for 2 (#150, #56) out of 42 Residents on Unit D during surveyor observation conducted in response to Complaint #3026233 and 1 (#106) out of 4 residents reviewed for dignity during the facility's recertification survey. The findings include: 1. On 6/4/26 at 6:56AM surveyors conducted observations of nursing Unit D in response to Complaint #3026233 which documented concerns regarding treatment of facility Residents by staff. On 6/4/26 at 6:56AM surveyors approached the end of the hallway farthest from the Unit D nursing station and heard Resident #150 from the hallway asking for water to drink and repeating: Water, H2O. Upon closer observation, no staff were present within Resident #150's room and Resident #150 was observed by surveyors laying in bed with no beverage present. Resident #165 was observed sleeping in their bed located in the same room across from Resident #150 with a cup of clear liquid sitting on their over bed table which was dated 6/2. 2. During continued dual surveyor observation of Unit D on 6/4/26 at 7:01AM surveyors heard from the hallway, Resident #56 repeatedly yelling: F this place. Surveyors observed Geriatric Nursing Assistant (GNA) #13 enter the room of Resident #56. GNA #13 was heard by surveyors inquiring as to why Resident #56 was upset, at which time Resident #56 stated to GNA #13: I'm wet. Resident #56 was heard by surveyors communicating to GNA #13 that they needed their incontinence product changed at which time GNA #13 was observed and heard by surveyors telling Resident #56: You have to wait, we are just getting started. On 6/4/26 at 7:02AM the surveyor conducted an interview of GNA #13 who confirmed the Resident was not on their assignment and they were unsure if the GNA assigned to that Resident's care had arrived for their shift yet. On 6/4/26 at 7:06AM the surveyor conducted an interview of Resident #56 at which time they continued to voice concern that they were wet from incontinence and needed staff assistance to be changed. GNA #13 was observed by surveyors entering and exiting several other Resident rooms. On 6/4/26 at 7:09AM the surveyor conducted an interview of Unit Manager #14 and night shift Nurse #15 who both confirmed that 2 out of 4 GNA's assigned to the 7am shift had not yet arrived, however, the two night shift GNA's had not yet left. On 6/4/26 at 7:11AM surveyors continued to observe GNA #13 entering and exiting other Resident rooms. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/26 at 7:17AM surveyors noted that Resident #56 had not yet received additional response by facility staff for their incontinence care concern. At this time, surveyors shared concerns with Unit Manager #14 who acknowledged the concerns and confirmed understanding of the concerns. On 6/4/26 at 7:26AM the surveyor shared the concern with the Director of Nursing who acknowledged the surveyor's concerns and stated: It's an education that needs to be reinforced again, there's no reason that if the two night shift GNA's are still here, they are getting paid on the clock, we still have four GNA's that is what is needed for the unit, they should be taking care of the needs even if the dayshift GNA' s are not here yet. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 3. On 6/01/2026 at 11:25 AM, Resident #106 was interviewed about how s/he enjoys life at the facility. Resident #106 stated that s/he loves living at the facility; however, some staff members speak to her/him like they are 5 years old. Resident #106 continued to state that s/he is more with it (comprehending) than some of the other residents, and that s/he doesn't like to be spoken to like that. Then s/he stated that s/he wanted to remain anonymous because s/he didn't want anyone to get in trouble. Resident #106 would not identify who the individuals were. On 6/04/2026 at 9:47 AM, the surveyor spoke with Resident #106 again about our initial conversation about the staff speaking to her/him as a child. Resident #106 confirmed that it has occurred on a number of occasions, but s/he could not give the exact remark stated. Resident #106 was asked if the surveyor could speak with NHA or the Unit Manager about this concern. Resident #106 stated that s/he trusted the NHA with their life, and of course, it was okay to tell them. On 6/04/2026 at 10:00 AM, the surveyor interviewed the NHA and Unit Manager #32 about the resident's concerns. The NHA and the Unit Manager were asked if they knew that Resident #106 felt as if some of the staff members spoke to him/her as if s/he were a child. The NHA stated that he knows Resident #106 well and that Resident #106 did not tell him this. The NHA then stated that he would start the grievance paperwork for the resident and that he would speak with Resident #106 about it. The NHA asked if Resident #106 gave any names of the staff members who treated them in this manner. The surveyor stated that Resident #106 did not state the names of the staff members who were speaking to her in this manner.		

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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. Based on record reviews and staff interviews, it was determined that the facility failed to ensure a resident's right to formulate an Advanced Directive. This was evident for 2 (#14, #38) out of 10 residents reviewed for Advanced Directives during the facility's annual recertification survey. The findings include: 1. On 6/01/26 at 1:35 PM, the surveyor conducted a record review. During the resident record review, the surveyor could not locate Resident #14's advance directive, nor could the surveyor locate documentation indicating that Resident #14 declined the opportunity to complete an advance directive when the facility offered him/her an opportunity to complete one. On 06/03/2026 at 10:29 AM, the surveyor interviewed the Social Services Director (SSD) #5. During the interview, the surveyor asked the SSD #5 if Resident #14 has an advance directive. The SSD #5 stated that Resident #14's Discharge Planning Psychosocial Assessment form, dated 12/28/25, indicates that Resident #14 has an advance directive; however, social services does not have an advance directive for Resident #14. The SSD #5 mentioned that social services has a financial power of attorney for Resident #14. The SSD #5 also mentioned that social services may have documented that Resident #14 has an advance directive on the Discharge Planning Psychosocial Assessment form, dated 12/28/25, because social services may have mistook Resident #14's financial power of attorney for the advance directive. On 06/04/2026 at 8:12 AM, the surveyor interviewed the SSD #5. During the interview, the SSD #5 indicated that she contacted Resident #14's responsible party to request a copy of Resident #14's advance directive. On 06/08/2026 at approximately 6:15 PM, during the survey's exit conference, the facility had yet to provide the surveyor with Resident #14's advance directive. 2. On 6/02/2026 at 12:52 PM, the surveyor conducted an interview with Resident #38 and asked if they had completed an advance directive during their stay at the facility. Resident #38 stated that s/he was unsure if they were given paperwork for advance directives. The surveyor conducted a record review of Resident #38's medical records. In the Discharge Planning Psychosocial Assessment that was completed on 1/18/2024, on page 5 of 6, Section C, question #8. It was documented that Resident #38 did not have an Advance Directive. The next question, 8a, asked if the resident was offered information about initiating an Advance Directive, which was not documented to be completed. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/2026 at 10:25 AM, the surveyor interviewed the Director of Social Services (DSS #5). She confirmed that advance directives were not offered to the resident per documentation. The surveyor asked for a copy of the Discharge Planning Psychosocial Assessment.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with staff, it was determined that the facility failed to maintain an environment free from restraints with the use of side rails in conjunction with a wedge and pillows for a resident. This was found to be evident for 1 (Resident # 171) reviewed for physical restraints during the annual recertification survey. The findings include: A physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. Bed rails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can help assist residents with movement and bed mobility. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A comprehensive assessment must be conducted and the medical symptom being treated must be identified to determine if bedrails can be used safely. On 6/1/2026 at 10:30AM during an initial tour of B wing unit, the Surveyor observed Resident #171 awake in bed with the head of the bed elevated about 30 degrees, bilaterally raised half side rails located in the middle of the bed frame, and an about 2-foot wedge placed under his/her left side and two pillows placed under his/her right side. The wedge and the pillows were situated under the white flat sheet and surrounded the resident. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A comprehensive MDS assessment is completed at admission, annually, quarterly, and with significant change. On 6/1/2026 at 12:15PM, a review of Resident #171's electronic medical record revealed the resident was admitted to the facility on [DATE]. An admission MDS assessment accepted on 2/19/2026 indicated the resident was rarely/never understood and rarely/never understands; a Brief Interview for Mental Status (BIMS) assessment was unable to be completed because the resident is rarely/never understood and cognition is severely impaired; the resident had functional impairment of the right upper extremity; and, the resident was dependent with activities of daily living (ADLs) and transfers and bed mobility. A Quarterly MDS assessment, accepted on 4/15/2026, indicated the resident was rarely/never understood and rarely/never understands; a Brief Interview for Mental Status (BIMS) assessment was unable to be completed because the resident is rarely/never understood and cognition is severely impaired; the resident has no functional impairment for upper and lower extremities; and, the resident required substantial/maximal or dependent assistance with ADLs, transfers, and bed mobility. An additional review revealed a Bed Side Rail Tool assessment, dated 3/10/2026, which identified the use of quarter side rails bilaterally to serve as an enabler to help with turning a repositioning and mobility. The side rail assessment failed to identify the alternatives tried and how the alternatives failed to meet the resident's needs prior to placing side rails; and failed to discuss the risk versus benefits and retrieve consent from the resident representative instead of a cognitively impaired resident. The most recent Bed Side Rail Tool assessment, dated 6/1/2026, identified the use of half side rails bilaterally to serve as an enabler to help with turning a repositioning and mobility. The side rail assessment failed to identify the alternatives tried and how the alternatives failed to meet the resident's needs prior to placing longer side rails. There was no documentation indicating the resident specific risks and benefits for the use of side rails. On 6/1/2026 at 1:30PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns regarding the Bed Side Rail assessments from 3/10/2026 and 6/1/2026. The DON stated that a review of Resident #171's Bed Side Rail assessments would be reviewed. On 6/3/2026 at 8:20AM, the Surveyor observed Resident #171 being fed breakfast. Half side rails were noted to be raised bilaterally. Pillows were noted to be on both sides between the resident and the side rails. On 6/4/2026 at 8:43AM during an interview conducted with the DON, the Surveyor was informed that the facility uses partial side rails to act as an enabler for bed mobility. The Surveyor expressed the concern that on multiple occasions, Resident #171 was observed in the bed with bilaterally raised half side rails at the middle of the bed frame with pillows and a wedge used to keep the resident in a specific position. This practice restricts a cognitively impaired residents' movements and prevents the resident from voluntarily getting up which defines a physical restraint. According to assessments, the resident is dependent on staff for bed mobility and transfers. The DON stated they would look into the Surveyor's concerns. On 6/5/2026 at 12:21PM, Resident #171 was observed in bed with a half side rail raised on the right side and pillows surround him/her on both sides. On 6/5/2026 at 12:43PM, an interview conducted with Unit Manager (UM) #24, of the B wing unit, revealed that side rails are used for bed mobility and assistance with transfers. If a resident would benefit from the use of side rails, the nurse would complete a side rail assessment, get consent, a physician's order, and develop a care plan. If the resident has cognitive impairment, nursing will still complete an assessment and have therapy evaluate the resident for bed mobility and transfer safety using bedrails. Resident #171 experience a decline in conditions since admission. UM #24 was unable to provide clinical justification for the current use of side rails. The Surveyor expressed the concerns regarding the completion of the resident's Bed Side Rail Tool assessment and the improper use of half side rails positioning devices while in bed. On 6/8/2026 during an interview with the Director of Rehab (DOR) #25, the Surveyor confirmed that there was no documentation from the rehab therapy department to support the use of side rails for Resident #171. During the resident's session with therapy, the resident experienced a decline and got worse. The Surveyor expressed these concerns with DON throughout the survey process.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interviews with staff, and review of facility reported incident #2669738 it was determined the facility failed to report and ensure timely reporting of injuries of unknown origin to the Office of Health Care Quality (OHCQ). This was evident for: 1.1 out of 9 facility reported incidents (#2669738) 2.1 Resident (#165) reviewed for change in condition 3.1 (#144) out of 6 residents reviewed for accidents during the facility's recertification survey. The findings include: 1. On 6/8/26 at 9:21AM the surveyor reviewed the facility provided complete investigative file for facility reported incident #2669738 which documented an initial self report form made to the Office of Healthcare Quality dated as made on 11/17/25 at 1:07AM for an allegation type of both physical abuse and injury of unknown source. Further review of the initial self report by the surveyor revealed documentation that on 11/16/25 at 9:30PM, GNA #17 became aware of multiple discolorations present on the face of Resident #158 and reported to Assistant Director of Nursing (ADON) #18 at 11:20PM. It was noted by the surveyor that on the initial self report form the following information was documented: The Resident refused to tell facility staff members what happened but told the officer that on Friday or the day of lunch, whoever served her lunch knocked the plate over because s/he did not like the food and hit his/her hand with the plate. The facility's initial self report form additionally was observed by the surveyor with documentation that law enforcement was contacted on 11/16/25 at 11:25PM. Surveyor review of a nursing progress note dated 11/16/25 at 9:43PM documented by the ADON revealed the following information: 1.) Primary chief complaint: ecchymosis (bruising), 2.) Head: Ecchymosis above rt brow and older appearing area higher on forehead, 3.) Diagnosis, Assessment/Plan: Unspecified Injury of head, initial encounter, primary, given s/he is on Eliquis (blood thinning medication) and unclear nature of incident, needs imaging, 4.) Transfer to ED (Emergency Department), 5.) This is an acute new problem, 6.) Condition is guarded, 7.) Transfer pt to ED via 911 EMS. Review by the surveyor of the facility's documentation present within the complete investigative file included definitions of key indicators of physical abuse which included: Unexplained bruises, fractures or marks. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review by the surveyor of the complete investigative file revealed an email documenting confirmation of the submission of the initial self report to the Office of Healthcare Quality as occurring on 11/17/25 at 1:09AM. On 6/8/26 at 10:16AM the surveyor shared concerns and conducted an interview of the facility Administrator who acknowledged and confirmed understanding of the surveyor's concerns. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 2. During surveyor review of Resident #165's medical record on 6/2/26 at 9:02AM documentation was observed regarding the presence of skin discoloration and hematoma. On 6/8/26 at 9:13AM the surveyor conducted an interview of the facility's Director of Nursing (DON) and inquired as to the origin of Resident #165's documented skin discoloration and hematoma at which time the DON reported to the survey team that they needed to review the Resident's medical record to refresh their memory on the events surrounding it. Further review of the medical record by the surveyor revealed a monthly follow up note documented by Nurse Practitioner (NP) #19 dated 5/7/26 at 3:30PM which documented their assessment of Resident #165 which included that the Resident was receiving comfort care, was fully dependent for activities of daily living and unable to participate in history of present illness due to cognitive impairment related to advanced dementia. Review by the surveyor of a health status note documented by Assistant Director of Nursing #18 dated 5/7/26 at 9:09PM revealed the following information: Resident noted with discoloration to the groin area during care giver clean his/her up, assessed small swollen but no open area or active drainage observed, NP notified. Review by the surveyor of documentation dated 5/8/26 at 2:30PM revealed NP #19 conducted a follow up assessment of the Resident which included the following information: 1.) groin swelling and discoloration, 2.) (Resident #165) is seen for evaluation of groin swelling and discoloration at the request of nursing staff, 3.) A small area of hematoma was observed in the groin area; skin is intact, 4.) nonverbal/confused/legally blind with advanced dementia, and full ADL dependence, 5.) Groin hematoma with discoloration, 6.) Hematologic/lymphatic: No easy bruising or bleeding, no enlarged lymph nodes, no history of anemia or clotting disorders, 7.) Contusion of groin initial encounter, small area of hematoma with associated discoloration (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed in the groin area. Review by the surveyor of a follow up assessment of Resident #165 by NP #19 dated 5/13/26 at 2:30PM revealed the following information: The hematoma which was noted to be resolving on 5/12/26, now appears to be spreading to his/her hips and flank area, with a large area of discoloration, and confirmed the Resident was not taking any blood thinning medications. On 6/8/26 at 11:09AM the surveyor conducted an interview of the facility's DON and inquired as to if the facility had made any self reports to the Office of Health Care Quality regarding Resident #165's injury of unknown origin at which time they confirmed that there was no self report made and no investigation performed. During the interview, the DON confirmed with the surveyor that they did consider this a situation in which required a self report to be made. After surveyor intervention, the DON expressed that they would begin investigation into the injury and a self report would be made. On 6/8/26 at 11:14AM the surveyor shared the concern with the facility's Administrator who acknowledged understanding of the concern and reported that they would look into where the facility was with their investigation. On 6/8/26 at 11:33AM the surveyor was approached by NP #19 at which time an interview was conducted. During the interview, NP #19 reported that per information relayed from facility staff, there was no fall or trauma, there was nothing. When the surveyor inquired as to how NP #19 ruled out trauma, they stated not really. NP #19 reported during the interview that on or around 5/21/26 they discussed with Unit Manager to follow up with staff to see if anything had happened to the Resident and at that time, facility staff were talked to and it was reported that nothing happened. At this time, the surveyor inquired as to the location of the injury at which time NP #19 showed the survey team a large area which extended from both inner thighs wrapping around their waist and extending up over and behind the hips. NP #19 stated that when she previously had observed it, it wasn't that extensive. During an interview conducted by the surveyor of NP #19 on 6/8/26 at 11:58AM, NP #19 reported that they had the discussion with the Unit Manager on 5/14/26 and confirmed that all lab work that they had ordered in response to the injury had come back normal. On 6/8/26 at 11:59AM NP #19 confirmed that this was a reportable injury, and the facility was now taking steps to perform investigation of it. NP #19 reported their initial observation of the injury included both thighs of the Resident and that they were initially called by facility staff to look at swelling and discoloration of the Resident. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. 3. On 6/8/2026 at 10:21AM, during a review of Resident #144's electronic medical record, the Surveyor discovered a 3/28/2026 eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers note which revealed that the resident was noted with redness and swelling to the right wrist and fingers and complained of pain when touched. Recommendations included an X-ray of the right wrist, hand, and fingers. Further review revealed a 3/30/2026 physician follow-up note (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stating the resident's x-ray was obtained on 3/28/2026 with the impression: right wrist no acute fracture. There was no documentation which identified the origin of the injury or a facility investigation into an injury of unknown origin reported to OHCQ. On 6/8/2026 at 11:00AM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #144 sustained an injury and that there was no documentation of an explanation for the injury, investigation by the facility, and report submitted to OHCQ. The DON stated that she would review the resident's medical record and the facilities reported incidents to determine if there was an investigation into the injury. On 6/8/2026 at 2:55PM, during a follow-up interview with the DON, the Surveyor confirmed there was no documentation of an explanation for Resident 144's injury and no facility reported incident regarding the resident's injury of unknown origin. The Surveyor was informed that education will be provided on documentation and reporting requirements of injuries of unknown origin. On 6/8/2026 at 3:50PM, the Assistant Director of Nursing (ADON) provided the Surveyor with a Facility Reported Incident Initial Report Form for Resident #144.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on recent interviews and a record review, it was determined that the facility staff failed to follow the appropriate discharge planning. This failure resulted in a delay in the community waiver program's processing of the resident's transition back to the community. This was evident for 1 (Resident #17) out of 2 residents reviewed for timely discharge planning during an annual survey. The findings include: An interview conducted on 6/1/26 at 1:30 PM, with the family Representative of Resident #17 who expressed concerns regarding the status of a Community Waiver Program application. They stated that they made multiple requests to Social Worker #5 in early April to arrange for this resident to be cared for at home. However, they reported that they have not received information regarding the specific program selected or the status of the application process. During an interview, on 06/03/26 at 9:06 AM the Director of Social Service #5 reported that the application was sent out 05/11/26, with assistance from Business Office Manager #33. However, the Director could not recall the destination address and was unaware of the current status or whether the application was accepted. The Director indicated that Business Office Manager #33 knew more detailed information regarding this matter. Consequently, the Director was to follow up with the Office Manager #33 to confirm the submission address. At this time, the Director considered her portion of the task complete as the application has been mailed. On 06/03/26 at 9:37 AM, a record review identified several concerns regarding the discharge planning documentation for Social Service #5. On 5/4/26, the note indicates that information regarding the Community First Choice Program was sent to the family and a call was made to the County Aging Unit to apply for the community waiver program. However, the waiver application was not mailed until 5/11/26. Furthermore, the discharge planning note dated 6/2/26 did not include any updates on the progress of the community waiver program. Interview, on 06/03/26 at 2:03 PM, the Business office manager #33 stated that she assisted with the waiver form but was unable to provide details on how it is tracked. Initially, she could not identify the mailing address used for the application. She later provided the address for the County Department of Health and Human Services but remained uncertain about which specific waiver program the application pertained to. Further interview, on 06/03/26 at 2:35 PM, the Corporate Regional Social Service #7 confirmed that Resident #17 applied for a waiver specifically called Money Follows the Person program. The Maryland Department of Health recently held a training session and provided a contact number to check application statuses. It was agreed that Social Worker #5 should have the necessary knowledge and preparedness to assist the family and ensure timely follow-through. On 06/03/26 at 3:19 PM, interview with Corporate [NAME] Social Service #7 and the Administrator discussing this family's discharge back to community request initiated in April 2026. During the discussion, it was noted that the status of this request had become unclear. Both Regional Social Service #7 and the Administrator agreed that mailing the community waiver program's application signifies the beginning of the Money Follows the Person process, not the conclusion of the Social Service #5's responsibilities. The findings indicate a deficiency in practice, including a lack of structured planning, insufficient communication with the family, and a failure to adequately track the waiver process.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents and staff, it was determined that the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect the resident's status. This was evident for 1 (Resident # 94) out of 3 residents reviewed for smoking and 1 (Resident #13) out of 3 residents reviewed for dental during the annual recertification survey. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A comprehensive MDS assessment is completed at admission, annually, quarterly, and with significant change. The findings include: 1. On 6/1/2026 at approximately 11:30AM, Resident #94 was observed smoking in the designated smoking area supervised by facility staff. On 6/2/2026 at 10:55AM the Surveyor discovered that the resident was admitted to the facility on [DATE], determined to be a smoker on admission, and was listed on the facility's current smokers list. On 6/2/2026 at approximately 1:30PM, Resident #94 was observed smoking in the designated smoking area supervised by facility staff. On 6/3/2026 at 1:07PM, a review of Resident #94's admission comprehensive MDS assessment, accepted 5/27/2026, Section J 1300 revealed No to current tobacco use. On 6/5/2026 at 11:59AM, during an interview with MDS Coordinator #12, the Surveyor expressed the concern that Resident #94 is a current smoker and was observed smoking on multiple occasions during the survey; however, the admission comprehensive MDS assessment, Section J1300 failed to indicate the resident's current tobacco use. The Surveyor was informed that in order to determine a resident's current smoking status within the 7-day lookback period, a review of the resident's activity calendar is completed to see if the resident actually smoked. Staff #12 stated they would review the resident's admission comprehensive MDS assessment. On 6/5/2026 at 12:10PM, during an Interview, Staff #12 acknowledged the error after reviewing the resident's activity calendar, which confirmed smoking activity on 5/20/2026 and 5/21/2026. Staff #12 stated that the assessment will be modified to reflect the resident's current status. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of these findings during the survey. 2. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation, on 06/01/26 at 9:24 AM, Resident #13 reported having only 4-5 teeth remaining, some of which were broken. The resident was eating a soft diet breakfast and could only chew on the left side due to these dental issues. Although the resident believed an appointment had been scheduled but still pending. A subsequent record review on 06/04/26 at 11:14 AM, Resident #13 was admitted to this facility on 12/16/25. Their diagnoses include rhabdomyolysis, dementia and prolonged hospitalization spanning from 08/15/25 to 12/16/25 prior to their transfer. The resident was noted as being able to make their needs known. The system confirmed that no dental appointment date was in place and the Minimum Data Set (MDS) revealed that the broken and loose teeth were not properly coded. Rhabdomyolysis is a serious medical condition where damaged muscle tissue rapidly breaks down and releases its cellular contents&mdash;like proteins and electrolytes&mdash;into the bloodstream. During an Interview on 06/05/26 at 12:37 AM, MDS Coordinator #12 acknowledged the omission, stating that the assessment omitted the proper codes because she relied on the admission nurse's incorrect assessment rather than identifying the dental issues independently. The administrator was informed of these findings the same day and agreed that this constitutes a deficient practice.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, it was determined that the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) was reviewed after admission to the facility and revised to reflect the resident's current status. This was found to be evident for 1 (Resident #129) out of 3 resident PASARR's reviewed during the annual recertification survey.Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long term care. PASRR requires that Medicaid-certified nursing facilities: evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID), offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings), and provide all applicants the services they need in those settings. A PASRR Level I screen determines if a nursing facility applicant has a suspected or diagnosed SMI, ID, or related condition (RC).Findings Include:On 6/2/2026 at 12:47PM, a review of Resident #129's electronic medical record revealed that the resident was initially admitted to the facility on [DATE] with diagnoses of, but not limited to, Cerebral Palsy and rheumatoid arthritis. Further review revealed a PASRR Level 1 dated 4/23/2026, completed by the hospital prior to admission, which failed to identify a diagnosis of Cerebral Palsy.On 6/3/2026 at 9:30AM, during an interview conducted with the Social Work Director (SW) #5 the Surveyor was informed that PASRR Level I screenings are completed by hospital staff prior to admission to ensure the resident is appropriate for placement at the facility. Upon admission, social work staff are responsible for reviewing and updating the PASRR if any inaccuracies are found. The Surveyor expressed the concern that Resident #129's PASRR failed to identify the resident's indicators for intellectual or developmental disabilities, or related conditions which include Cerebral Palsy. SW #5 stated that they would look into the Surveyor's concern with Regional Social Worker #7.On 6/5/2026 at 3:30PM, a review of Resident #129's PASARR documentation provided by Staff #7 confirmed inaccurate documentation of resident status. The facility failed to ensure the PASRR was reviewed after admission and revised, as needed, to reflect the resident's current status, which should have prompted further evaluation to determine if the resident required any specialized services. Staff #7 acknowledged the Surveyor's concerns and stated that the facility is providing training to the social work department regarding reviewing PASRR's for accuracy and resubmitting as necessary.Surveyor findings reviewed with the Nursing Home Administrator (NHA), SW #5, and the Director of Nursing (DON) during the survey process.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on resident interviews, record reviews, and staff interviews, it was determined that the facility failed to ensure that quarterly interdisciplinary care plan meetings were held for residents. This was evident for 2 (Resident #34 and #38) out of 8 residents reviewed for care planning during the facility's annual recertification survey. The findings include: 1. On 06/01/2026 at 8:23 AM, the surveyor interviewed Resident #34. During the interview, Resident #34 stated that he/she has not had a care plan meeting. On 06/03/2026 at 8:12 AM, the surveyor conducted a record review. The record review revealed that there is a Multidisciplinary Care Conference - V3 form, dated 2/23/26 which states that the resident had a care plan meeting on 2/23/26 at 12:00 PM. On 06/03/2026 at 8:22 AM, the surveyor conducted a record review. The record review revealed that there is a Multidisciplinary Care Conference - V3 form, dated 3/21/25 which states that the resident had a care plan meeting on 3/21/25 at 11:00 AM. On 06/03/2026 at 8:47 AM, the surveyor interviewed the Director of Nursing (DON) #2. During the interview, the surveyor asked the DON #2 to describe the frequency of resident care plan meetings. The DON #2 stated that care plan meetings should be held at admission and quarterly. The surveyor also asked the DON #2 who is responsible for scheduling resident care plan meetings. The DON #2 stated that Social Services is responsible for scheduling resident care plan meetings. On 06/03/2026 at 9:00 AM, the surveyor interviewed the Social Services Director (SSD) #5. During the interview, the surveyor asked the SSD #5 to describe the frequency of resident care plan meetings. The SSD #5 stated that resident care plan meetings are held at admission, quarterly, yearly and if the resident experiences a significant change. The surveyor asked the SSD #5 to describe the process for scheduling resident care plan meetings. The SSD #5 stated that she calls the attendees, and if the attendees have an e-mail address, she e-mails them an Outlook calendar invite for the care plan meeting. If the attendee does not have an e-mail address, she will mail them a care plan meeting invitation letter. The SSD #5 stated that the attendees can attend the care plan meeting via telephone, virtually via Microsoft Teams, or in-person. The surveyor made the SSD #5 aware that, according to Resident #34's most recent Multidisciplinary Care Conference - V3 form dated 2/23/26, Resident #34's last care plan meeting was held on 2/23/26. The SSD #5 indicated that another care plan meeting should have been held for Resident #34 in May 2026. Also, the SSD #5 indicated that according to facility documentation, prior to Resident #34's care plan meeting on 2/23/26, Resident #34 had a care plan meeting on 3/21/25, which was approximately eleven months between care plan meetings. The SSD #5 also indicated that she became the Social Services Director in August 2025, and prior to then the Social Services department was experiencing staffing challenges. The surveyor (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked the SSD #5 what is the expectation of holding resident care plan meetings. The SSD #5 stated that the expectation is to hold resident care plan meetings at admission, quarterly, yearly and if there is a significant change. 2. On 6/02/2026 at 1:17 AM, during an interview with the surveyor, Resident #38 was asked if s/he attended any care plan meetings with the facility. Resident #38 stated that s/he was unsure if they had attended any care plan meetings lately. On 6/3/2026 at 10 AM, the surveyor conducted a record review of Resident #38's medical records. During this review, it was noted that the last care plan meeting was on February 23, 2026, and the previous one was done on December 8, 2022. On 6/05/2026 at 1:26 PM, an interview was conducted with the Director of Social Services (DSS #5), and she asked how often care plan meetings are held. DSS #5 stated that they should be conducted annually, quarterly, and if there is a significant change in the resident. The surveyor asked DSS #5 about the past care plan meetings that were done with the resident or with the Resident Representative for the past year. The surveyor asked if there were any care plan meetings completed other than the ones noted in the Electronic Medical Record (EMR). The DSS #5 stated that the last care plan meeting was done in February 2026, and before that, it was completed in December 2022. DSS #5 did not give an explanation of why the care plan meetings had not been done quarterly or annually for the past 4 years. The surveyor asked for a copy of the completed care plan meetings documented.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews with the resident and staff, and review of complaint #2655036, it was determined that the facility failed to ensure a resident's call bell was in reach and document and report a resident's fall and administer medications according to professional standards of practice. This was found to be evident for 1 (Resident #41) out of 6 residents reviewed for accidents and 1 (#2655036/Resident #184) out of 6 complaints reviewed during the annual recertification survey. The findings include: 1. On 6/1/2026 at 8:45AM, during an initial interview conducted with Resident #41, the Surveyor learned that a couple days prior, the resident slid out of his/her wheelchair and hurt his/her tail bone while reaching for the call bell which was on the other side of the bed at the time. The resident continued to say that a facility staff member observed him/her on the ground upon returning to the room and called for another facility staff member to assist the resident back into the bed. On 6/3/2026 at 1:39PM, a review of Resident #41's electronic medical record failed to reveal documentation of a fall since admission on [DATE]. During an interview conducted with the Unit Manager (UM) #24 of the B wing unit on 6/3/2026 at 1:50PM, the Surveyor learned that Resident #41's fall a couple days ago was not reported and there was no record or documentation of the fall anytime during their admission to the facility. The Surveyor reported that Resident #41 stated that they fell a couple of days ago in their room. UM #24, in the Surveyor's presence, interviewed the resident in order to submit a formal fall report. The resident informed UM #24 that facility staff told them not to report the fall. UM #24 stated they would start an investigation to determine the staff involved and the circumstances surrounding the resident's fall. On 6/3/2026 at 2:10PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #41 informed both the Surveyor and UM #24 that they sustained a fall on 5/30/2026 while trying to reach for the call bell; however, there was no documentation of a fall in the resident's medical record. The Surveyor was informed that the facility would start an investigation into Resident #41's fall. On 6/4/2026 at 8:43AM, the DON confirmed that Resident #41 sustained a fall on 5/30/2026 during the evening shift while trying to reach for the call bell and the nurse failed to document and report the incident at the time of occurrence. Facility staff involved received education on ensuring call bells are within reach, timely reporting of falls and incidents, and completing required documentation. 2. On 6/3/26 at 12:17 PM, the surveyor reviewed complaint # 2655036. Complaint #2655036 indicated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #184's medication was not administered. On 6/8/26 at 9:08 AM, the surveyor reviewed the resident's medical records. The resident record review revealed that the resident's Medication Admin Audit Report indicated that the resident received the following medications late on 09/18/25: -Empagliflozin Oral Tablet 10 MG (Empagliflozin) for diabetes mellitus, was scheduled for 8:00 AM on 9/18/25, administered at 9:24 AM on 9/18/25, and documented at 9:27 AM on -Escitalopram Oxalate Oral Tablet 20 MG (Escitalopram Oxalate) for depression, was scheduled for 8:00 AM on 9/18/25, administered at 10:05 AM on 9/18/25, and documented at 10:08 AM -Bumetanide Oral Tablet 1 MG (Bumetanide) for CHF, was scheduled for 8:00 AM on 9/18/25, administered at 10:06 AM on 9/18/25, and documented at 10:08 AM -Lidocaine HCl External Lotion 1 % (Lidocaine HCl) for lower back pain, was scheduled for 8:00 AM on 9/18/25, administered at 10:07 AM on 9/18/25, and documented at 10:08 AM -Atovaquone Oral Suspension 750 MG/5ML (Atovaquone) for PCP prophylaxis, was scheduled for 8:00 AM on 9/18/25, administered at 10:06 AM on 9/18/25, and documented at 10:08 AM -Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) for bowel regimen, was scheduled for 8:00 AM on 9/18/25, administered at 10:09 AM on 9/18/25, and documented at 10:09 AM -Spironolactone Oral Tablet 50 MG (Spironolactone) for CHF, was scheduled for 8:00 AM on 9/18/25, administered at 10:09 AM on 9/18/25, and documented at 10:09 AM -Insulin Asp Prot & Asp FlexPen (70-30) 100 UNIT/ML Suspension pen-injector Inject 18 unit for diabetes mellitus 2, was scheduled for 8:00 AM on 9/18/25, administered at 10:26 AM on 9/18/25, and documented at 10:29 AM -Calcitriol Oral Capsule 0.25 MCG (Calcitriol) for CKD, was scheduled for 8:00 AM on 9/18/25, administered at 2:42 PM on 9/18/25, and documented at 2:27 PM -Genvoya Oral Tablet 150-150-200-10 MG (Elvitegravir-Cobicistat-Emtricitabine-Tenofovir Alafenamide) for HIV/AIDS, was scheduled for 8:00 AM on 9/18/25, administered at 3:00 PM on 9/18/25, and documented at 8:06 PM -rifAXIMin Oral Tablet 550 MG (Rifaximin) for HIV/AIDS, was scheduled for 8:00 AM on 9/18/25, administered at 9:06 AM on 9/18/25, and documented at 8:07 PM -PredniSONE Oral Tablet 50 MG (Prednisone) for IgA, was scheduled for 8:00 AM on 9/18/25, administered at 10:07 AM on 9/18/25, and documented at 8:07 PM (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lidocaine External Cream 4 % (Lidocaine) for back pain, was scheduled for 10:00 AM on 9/18/25, administered at 2:42 PM on 9/18/25, and documented at 2:42 PM -Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) for supplement, was scheduled for 1:00 PM on 9/18/25, administered at 4:28 PM on 9/18/25, and documented at 4:29 PM on 9/18/25; -Ferrous Fumarate Oral Tablet 324 MG (Ferrous Fumarate) for supplement, was scheduled for 1:00 PM on 9/18/25, administered at 3:28 PM on 9/18/25, and documented at 4:29 PM -Lactulose Oral Solution 10 GM/15ML (Lactulose) for liver cirrhosis, was scheduled for 2:00 PM on 9/18/25, administered at 3:28 PM on 9/18/25, and documented at 4:29 PM on 9/18/25. On 06/08/26 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) #2. During the interview, the surveyor mentioned to DON #2 that according to Resident #184's Medication Admin Audit Report, Resident #184 received medication late on 9/18/25. The surveyor asked the DON #2 what the expectation is when administering medication to residents. The DON #2 stated that the expectation is to administer medications one hour before or one hour after the medication is due.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observations, record review, and interviews with staff, it was determined that the facility failed to:1.Maintain a functional communication system for a non-English speaking resident and develop and implement a person-centered care plan to provide the best resident care.2. Provide the necessary activities of daily living (ADL) functional therapy or restorative routines required to prevent avoidable decline to ensure resident maintained the highest practicable level of physical well-being regarding ADLs needs. This was found to be evident for 2 (#171, #13) out of 4 residents reviewed for ADLs during the annual recertification survey. The findings include: 1. On 6/1/2026 at 10:30AM, during an initial tour of the B wing nursing unit, the Surveyor attempted to conduct an interview with Resident #171. While alert and responsive to their name, the resident did not respond to any further questions, verbally or non-verbally during Surveyor interaction. During a review of Resident #171's electronic medical record on 6/4/2026 at 9:34AM, the Surveyor discovered a Discharge Planning Psychosocial assessment completed on 2/12/2026 and a Minimum Data Set (MDS) admission assessment accepted 2/19/2026 which identified the resident as Chinese ethnicity. The resident's care plan for risk for complications related to impairment of communication and potential for poor health literacy related to Alzheimer's dementia, is hard of hearing and English is not the first language, failed to identify the resident of Chinese ethnicity, the resident's primary language, use of interpretation services to communicate with the resident. Further review of the resident's electronic medical record failed to reveal documentation of the use of the interpreter services provided by [Language Interpretation Company] to communicate with the resident. On 6/5/2026 at 12:45PM during an interview with Unit Manager (UM) #24 for the B wing unit, the Surveyor was informed that the facility utilizes a third-party language line for phone interpretation services to communicate with non-English speaking residents. The services can be accessed through the resident's room phone and/or employee's cell phone. Facility staff are aware of the interpreter services provided by [Language Interpretation Company] to communicate with the resident. UM #24 provided the Surveyor with a copy of the [Language Interpretation Company] information sheet. The Surveyor expressed the concern that during observations of Resident #171 on 6/1/2026, 6/2/2026, 6/3/2026, and 6/5/2026, the Surveyor failed to observe staff utilizing the [Language Interpretation Company] to communicate with the resident during activities of daily living and meals. The Surveyor informed UM #24 that based on activity and rehab staff interviews, Resident #171 is Chinese ethnicity and his/her primary language is Mandarin. A review of Resident #171's care plan failed to identify the resident's ethnicity, primary language, and the use of the facility's third party language line for phone interpretation services. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/2026 at 2:45PM the Surveyor made the Director of Nursing aware of their communication concerns. 2. Observation, 06/01/26 at 9:29 AM, Resident #13 was walking in the hallway with unsteady gaits. The resident reported that s/he had not received rehabilitation services since admission and was told by staff his/her legs' muscles and body balance were becoming weak. A record review conducted on 06/08/26 at 9:14 AM revealed that Resident #13 was admitted to this facility on 12/16/25. Their diagnoses include rhabdomyolysis, dementia and prolonged hospitalization spanning from 08/15/25 to 12/16/25 prior to their transfer. From recent assessment this resident was noted as being able to make their needs known. Rhabdomyolysis is a serious medical condition where damaged muscle tissue rapidly breaks down and releases its cellular contents&mdash;like proteins and electrolytes&mdash;into the bloodstream. The focus should remain on preventing secondary muscle complications and managing contractures. To gradually restore baseline strength, it is necessary to implement range-of-motion (ROM) exercises, light aerobic training, and submaximal resistance training A further review has identified a discrepancy regarding resident care orders and subsequent evaluations. On 12/16/26, Medical Director #4 issued active orders for Physical, Occupational, and Speech therapy evaluations and treatment, admitting the resident to a skilled level of care. However, subsequent rehabilitation screenings conducted by Physical Therapist #26 on 12/18/26 and Occupational Therapist #27 on 03/23/26 indicated no change across all functional, speech, and behavioral areas. These screenings suggest that therapy was not required at those times, which directly contradicts the Medical Director's orders. Noted the multidisciplinary care plan conference from 12/28/25 revealed that the Director of Social Work #5 identified rhabdomyolysis as the treating diagnosis and noted continue the PT/OT regimen. However, despite this documentation, the resident did not receive any rehabilitation therapy. Additionally, under the multidisciplinary care plan conference plan Section 6. restorative care summary signed by the Director of Rehab #25 noting this resident required moderate assistance for functional mobility and supervision for ADLs. During an interview on 06/08/26 at 10:45 AM with Director of Rehabilitation #25 who explained that Resident #13 was deemed ineligible for therapy due to a lack of insurance approval. However, this resident has a second insurance to cover. She knew that the resident required moderate assistance for functional mobility and supervision for ADLs to improve leg strength and balance, but clarified that the situation would only differ if authorization had been obtained from the primary insurance. On 06/08/26 at 11:32AM Interview with Restorative staff # 29 revealed that her schedule did not include Resident #13. She has other residents for all kinds of restorative activities such as ambulation daily. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Finally, at 2:12 PM, these findings were discussed with the Administrator. Despite the Medical Director's orders, the multidisciplinary care conference plan notes that the resident required therapy, ADL's assistance and supervision and Resident #13's request. the facility staff failed to provide necessary functional therapy or restorative routine. It was determined that the exclusion from these services was based on insurance disapproval status. This represents a bias and a deficient practice in addressing Resident #13's avoidable functional decline and their preferences. The Administrator has agreed with these findings and stated that he will correct this deficient practice promptly.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with staff, it was determined that the facility failed to provide an ongoing, individualized program of activities for a dependent resident that support their physical, mental, and psychosocial well-being. This was found to be evident for 2 (Resident #6 and #171) out of 3 residents reviewed for activities during the annual recertification survey. The findings include: 1. During an observation on 6/1/26, at 11:17 AM, Resident #6 was found sleeping on their stomach and expressed uncertainty regarding how to join activity groups. No activity staff were present in the area, and a room check confirmed a lack of self-stimulation materials. Later that day, activity staff entered the room to update a calendar but failed to interact with the resident. On 06/03/26 at 11:42 AM, a record review was performed for this resident who was admitted on [DATE]. The resident's diagnoses include paranoid schizophrenia, dementia, and anxiety disorder with depressive episodes. Despite these conditions, the resident was able to make their needs known. On 06/03/26 at 12:32 PM, met with the Director of Activity #11. During the interview, the Director stated that staff visit residents requiring one-to-one care daily and continue to encourage all residents participating in group activities. On 06/04/26 at 1:56 PM, Resident #6 found sleeping on their stomach again for over two hours. During this observation period, facility staff did not provide one-to-one activity visits, nor was any self-entertainment device provided to the resident. A follow-up record review conducted at 2:59 PM that same day revealed the following one-to-one engagement compliance: - April Daily Log: 6% - May Daily Log: 48% Regarding the interview conducted on 06/04/26, at 2:56 PM, the Director of the Activity #11 was notified of low daily one to one visit activity rates, specifically during the month of April. Additionally, the staff failed to provide self-stimulation materials and devices intended for residents use. A follow-up interview with the Administrator confirmed that the facility staff failed to provide ongoing, personalized activities necessary to meet the resident's physical, mental, and psychosocial needs; concerning an on-going deficient practice. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. On 6/1/2026 at 10:30AM, during an initial tour of the B wing nursing unit, the Surveyor observed Resident #171 lying in bed with the head of the bed elevated about 30 degrees. The resident was awake and alert. The resident's television was off and the remote was located on the bottom shelf of the nightstand next to the bed. There were no stimulating activities observed at the resident's bedside. On 6/3/2026 at 8:15AM, during an interview with GNA #28, the Surveyor learned that they had not observed the resident participating in any activities. On 6/3/2026 at 12:00PM, a review of Resident #171's electronic medical record revealed that the resident was admitted to the facility on [DATE] and had diagnoses of, but not limited to, Alzheimer's disease, dementia, and depression. Further review revealed that the resident is Chinese ethnicity and English is not the resident's primary language. 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. Additionally, a review revealed a care plan with a focus, 1:1 ACTIVITIES: [Resident #171] prefers or requires 1:1 and family centered activities created on 2/11/2026 with revisions on 4/28/2026; a goal which stated, [Resident #171] will be satisfied with their 1:1 activities provided thru the review period created on 2/11/2026 with revisions 2/23/2026; and interventions stated, Provide 1:1 activities in the room or location that is [Resident #171's] preference as needed. The care plan failed to identify resident specific activities to tailored to the resident's specific capabilities and incorporate 1:1 engagement and cultural preferences. On 6/3/2026 at 12:11PM, an interview conducted with Director of Activities #11 activity staff make rounds every morning to inform the residents about the activities for the day. Resident #171 likes to stay in the room and receives 1:1 visits from activity staff. The Surveyor informed Staff #11 that during multiple visits, the Surveyor failed to see the resident engaged in any type of activity. The TV was off, the remote was on the bottom shelf of the nightstand, and there were no stimulating activities at the resident's bedside. The visits are documented by activity staff after every interaction. Activity assistant #30 conducts activities and 1:1 visits on the B wing. The Surveyor requested Staff #11 to provide documentation of the resident's 1:1's and any other activity participation/invitation. On 6/3/2026 at 1:45PM, a review of the activities Event Calendar Reports for March 2026 through June 2026 showed significant gaps in documentation, including no recorded activities for April 2026. During an interview conducted with Activity Assistant #30 on 6/5/2026 at 1:35PM, the Surveyor (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expressed the concern that during the survey from 6/1/2026 through 6/5/2026, the Surveyor did not observe Resident #171 engage in any activities or provided 1:1 room visits and the resident was observed in their room with no stimulating activity. Staff #30 informed the Surveyor that they had not seen the resident since May 2026.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, interviews with staff, and a review of complaint #3026233, it was determined that the facility failed to 1.) provide supervision of residents and 2.) ensure that standard electrical power strips were not used for resident's motorized beds. This was found to be evident for 1.) 1 nursing unit (D Wing) out of 4 nursing units observed and 2.) 1 (Resident #171) out of 20 residents observed on the A wing nursing unit during the annual recertification survey. The findings include: 1. Review by the surveyor of Complaint #3026233 on 6/1/26 at 8:29AM revealed an allegation in which a night shift nurse and certified nursing assistant (GNA) were observed sleeping behind a desk. On 6/4/26 at approximately 3:50AM this surveyor and the survey team entered the facility unannounced and began conducting observations of the facility's nursing units and staff. On 6/4/26 at 3:54AM surveyors observed night shift Licensed Practical Nurse (LPN) #15 sitting in a chair at the Unit D nurse's station sleeping with their eyes closed and head resting on their right shoulder. Two computers at the nursing desk in front of them were observed with dark screens. On 6/4/26 at 3:55AM surveyors observed GNA #20 sitting at a Resident dining table sleeping in front of their computer which had a dark screen, with their upper body resting on their arms on the table and their eyes closed. The dining table was observed located in front of the nurse's station and kitchenette on Unit D. On 6/4/26 at 3:55AM surveyors observed GNA #21 sleeping in a geri-chair with their feet up, eyes closed, their sweatshirt hood up on their head, and shoes off. On 6/4/26 at 3:55AM surveyors toured the Unit D hallway while staff continued to sleep. On 6/4/26 at 3:55AM surveyors observed a Resident room door which was closed with signage that read in capitalized letters: This door must remain open at all times. On 6/4/26 at 4:01AM the surveyor observed and reviewed the staffing sheet assignment document posted at the nurse's station which documented that the following staff were responsible for the care of 43 Residents during the 11pm-7am shift : LPN #15, GNA #20, and GNA #21. Surveyors noted that 3 out of 3 staff responsible for direct supervision and care of the D Unit were all observed to be sleeping. On 6/4/26 at 4:04AM surveyors shared concerns and conducted an interview with the facility's Registered Nurse Supervisor (RNS) #22 who confirmed they were the supervisor in charge of the building, and stated: I try to do rounds, but I can't be there all the time. When surveyors shared (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns with RNS #22, they acknowledged the concerns and stated: Yes, I do understand. On 6/4/26 at 4:54AM this surveyor in the presence of the survey team, shared concerns with the facility's Administrator who acknowledged and confirmed understanding of the concerns. The facility Administrator informed surveyors that the involved facility staff would be addressed prior to leaving their shift. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit. Prior to surveyor exit from the facility, the facility Administrator provided the following documentation which was reviewed by the surveyor: -Sign in sheet dated 6/4/26 for facility staff education conducted regarding sleeping on duty being strictly prohibited -Corrective action forms dated 6/4/26 noting suspension each of GNA #20, GNA #21 and LPN #15 -Education sheets signed each by GNA #20, GNA #21, and LPN #15. 2. On 6/1/2026 at 10:30AM, during an initial tour of the A wing nursing unit, Resident #171's motorized bed's power cord was observed plugged into a black standard electrical power strip instead of a wall outlet. On 6/5/2026 at 2:07PM, during an interview with the Director of Maintenance (DOM) #16, the Surveyor expressed the concern that Resident #171's motorized bed power cord was plugged into a standard electrical power strip and not directly into the wall outlet. DOM #16 informed the Surveyor that during room rounding, the maintenance staff inspect beds for safety, including power cords. During a follow-up observation with DOM #16, the resident's motorized bed power cord was removed from the standard electrical power strip and plugged directly into the wall outlet. DOM #16 confirmed that motorized bed power cords must be plugged directly into the wall outlet.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review it was determined the facility failed to ensure staff followed professional nursing standards for medication administration. This was evident for 1 (#127) out of 2 Residents reviewed for hospitalization during the facility's recertification survey. The findings include: Review of Resident #127's medical record by the surveyor on 6/4/26 at 6:37AM revealed there was no evidence found to be present in the medical record to show the following medications had been administered according to active medical orders for the Resident to receive them on 5/27/26 at 6:00PM: -Debrox Solution 6.5% Instill 5 drop in both ears two times a day for ear wax for 7 days -Metoprolol Tartrate Oral Tablet 25mg Give one tablet by mouth two times a day related to essential primary hypertension . On 6/5/26 at 9:48AM the surveyor shared concerns with and conducted an interview of the facility's Director of Nursing who reported to the surveyor that they could not give an answer as to why there was no documentation surrounding the 5/27/26 6:00PM medication administration and that they assumed the medications were given, but not signed off. The DON further reported to the surveyor during the interview that they reviewed the Resident's medical record and no further documentation for a reason as to why medications were not signed off could be found. The DON confirmed there were no holidays or leaves of absence of the Resident during the time in which the medications were to be administered on 5/27/26. The DON further stated to the surveyor during the interview: I know that if it's not documented, it is considered not done. On 6/8/26 all concerns were shared by the surveyor with the facility's Administrator prior to surveyor exit.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Potomac Valley Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and staff interviews, it was determined that the facility failed to ensure that residents were free of any significant medication errors. This was evident for 1 (Resident #172) out of 10 residents reviewed for medication errors during this annual survey. The findings include: On 6/03/2026 at 8:15 AM, during review of the resident's medications, it was noted by the surveyor that Resident #172 was ordered for Zinc 220 mg; however, the facility only has Zinc 50 mg available in the facility's house stock. The nurses have been given 4 1/2 pills to the resident, making the dose 225 mg. The surveyor spoke to the Unit Manager (UM #32) and discussed the concern about the Zinc dosage and the number of pills the resident is receiving. UM #32 stated that she was unaware of the discrepancy in the dosages and stated that she would reach out to the Nurse Practitioner and see if the order can be changed to accommodate the dosage of Zinc that is available at the facility. The UM #32 returned to the surveyor at 11:30 AM, and stated that she was able to speak with the Nurse Practitioner and changed the order to Zinc 200 mg daily.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Potomac Valley Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and interviews, it was determined that the facility failed to maintain readily accessible PASSARs in the resident's medical record. This was evident for 1 (Resident #7) out of 1 resident reviewed for PASSARs during the facility's annual recertification survey. The findings include: On 06/03/2026 at 10:06 AM, the surveyor conducted a record review. The record review revealed that Resident #7's level 1 PASSAR was completed on 06/11/2025 by the Social Services Director (SSD) #5. Resident #7's level 1 PASSAR states PASRR level I is approved, will need a PASRR level II due to IP psyche admission for schizophrenia with hallucinations. Requesting facility is responsible for contacting the local AERS office to start the Level II process. During the record review, the surveyor was unable to locate Resident #7's level 2 PASSAR. On 06/03/2026 at 10:36 AM, the surveyor interviewed the SSD #5. During the interview, the surveyor asked the SSD #5 if Resident #7 has a level 2 PASSAR. The SSD #5 indicated that she was able to locate a level 1 PASSAR in Resident #7's medical record; however, she was unable to locate a level 2 PASSAR in Resident #7's medical record. The surveyor asked the SSD #5 if she was able to log into Telligen to determine if a level 2 PASSAR was completed for Resident #7. At that time, the SSD #5 logged into Telligen and she mentioned to the surveyor that she was unable to see if a level 2 PASSAR was completed for Resident #7 due to her not having visibility rights. On 06/04/2026 at 8:25 AM, the surveyor interviewed the SSD #5. During the interview, the surveyor asked the SSD #5 if she was able to obtain a copy of Resident #7's level 2 PASSAR from Telligen. The SSD #5 stated that she requested visibility rights from Telligen and is still awaiting for the visibility rights to be granted. The SSD #5 indicated that she would follow up with the surveyor once she obtains visibility rights. On 06/05/2026 at 2:13 PM, the surveyor interviewed the Regional Social Worker (RSW) #7. The surveyor mentioned to the RSW #7 that the SSD #5 indicated that she is unable to see if there is a completed level 2 PASSAR for Resident #7 in Telligen. At that time, the RSW #7 logged into Telligen and she indicated that she is also unable to see if there was a level 2 PASSAR completed for resident #7. On 06/08/2026 at 12:32 PM, the surveyor interviewed the [NAME] County Health Department via telephone. During the interview, the surveyor asked the [NAME] County Health Department if a level 2 PASSAR was completed for Resident #7. The [NAME] County Health Department stated that a level 2 PASSAR was completed for Resident #7 on 7/16/25. The surveyor asked the [NAME] County Health Department to e-mail a copy of Resident #7's level 2 PASSAR. On 06/08/2026 at 12:47 PM, the surveyor received Resident #7's level PASSAR, via e-mail, from the [NAME] County Health Department. On 06/08/2026 at 12:53 PM, the Director of Nursing (DON) #2 provided the surveyor with a copy of Resident #7's level 2 PASSAR.		