

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  Doctors Community Rehabilitation and Patient Care		STREET ADDRESS, CITY, STATE, ZIP CODE  6710 Mallery Drive Lanham, MD 20706	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, and observations, the facility failed to maintain an environment free from staff-to-resident verbal and non-verbal abuse for 2 (Resident #28, #3) of 19 residents. Specifically, 1) Housekeeper 1 (HK1) used curse words toward and made a threatening gesture toward Resident (R) 28 by raising his/her middle finger one time within R28's bedroom and when 2) General Nursing Assistant (GNA) verbally abused R3 and used derogatory comments while providing care. The facility census was 126. The facility implemented effective and thorough corrective measures following these incidents and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 1) 8/1/24 and 2) 5/10/25. The findings include:</p> <p>1) A review of the facility's Center Operations Policies and Procedures Manual including a policy titled, &amp;ldquo;OPS300 Abuse Prohibition,&amp;rdquo; dated 7/1/13 with a revision dated 10/24/22, Revision 6.0 revealed, &amp;ldquo;Policy: Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter &amp;ldquo;patient&amp;rdquo;) property, and exploitation for all patients&amp;hellip;Federal Definitions: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish&amp;hellip; It includes verbal abuse, sexual abuse, physical abuse, and mental abuse&amp;hellip;Verbal Abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance&amp;hellip; Mental Abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation&amp;hellip;PURPOSE: To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment&amp;hellip;for all patients.&amp;rdquo;</p> <p>Record review of R28&amp;rsquo;s electronic medical records revealed he/she was admitted on [DATE] with diagnoses including Congestive Heart Failure, Pulmonary Hypertension, Atrial Fibrillation, Morbid Obesity, Hypertensive Heart Disease with Heart Failure, Difficulty Walking, Muscle Weakness, and Adjustment Disorder with Anxiety. Review of R28&amp;rsquo;s Minimum Data Set (MDS) assessments dated 3/15/24 and 3/17/25, revealed Brief Interview for Mental Status (BIMS) scores of 15 on both assessments, an indication of intact cognition. Further review of progress notes dated 7/29/24 through 8/1/24 revealed R28 was assessed by nursing and social services following the incident without ill effects noted.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's investigation initiated on 7/29/25 revealed the alleged perpetrator was identified and placed on administrative leave. Further review of the 5-day follow submitted on 8/1/24, revealed the allegation was verified, and the perpetrator was terminated from the facility.</p> <p>In an interview on 8/28/25 at 1:30 p.m., R28 said he/she has enjoyed his/her care at the facility, sharing that he/she felt it was now time for him/her to move to an assisted living facility, adding that the facility has been helpful in initiating and facilitating this request. When asked about any problems or issues, he/she stated, "they have been nice to me." When inquiry was made specifically about the facility-reported incident, R28 recalled the incident and stated he/she has not seen that person since the incident and he/she was happy that he/she no longer had to worry about that housekeeper being disrespectful and rude to him/her.</p> <p>During an observation on 8/28/25 at 1:30 p.m., R28 appeared well-groomed and cognitively intact. He/She engaged this surveyor in pleasant conversation. He/She said he/she has enjoyed his/her care at the facility, sharing that he/she felt it was now time for him/her to move to an assisted living facility, adding that the facility has been helpful in initiating and facilitating this request. When asked about any problems or issues, he/she stated, "they have been nice to me." When inquiry was made specifically about the facility-reported incident, R28 recalled the incident and stated he/she has not seen that person since the incident and he/she was happy that he/she no longer had to worry about that housekeeper being disrespectful and rude to him/her.</p> <p>In an interview on 8/28/25 at 11:50 a.m., the Director of Environmental Services (DES) stated that both R28 and an unidentified Geriatric Nurse Aide (GNA) reported the incident to him/her and to the former Director of Nursing (DON) immediately following the incident. DES stated HK1 was immediately placed on administrative leave, pending an investigation. Once the investigation was completed and verified, HK1 was terminated from the facility. The DES stated his/her expectation was that no one should ever curse at or "flip off" a resident and that suspected abuse of a resident "should be reported immediately." DES said education on abuse and neglect is mandatory for environmental services staff annually, and as needed, adding that re-education was provided to the entire department following the incident.</p> <p>2) Record review of the facility's abuse, neglect and exploitation policy dated 07/01/13, and last revised on 10/24/22 documented the following:</p> <p>The facility prohibits abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all Residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Facility also strives to comply with the Elder Justice Act (EJA). Under the EJA, employees are designated as mandated reporters and are obligated to immediately report any reasonable suspicion of a crime against a patient/Resident. Reporting a reasonable suspicion of a crime only to an immediate supervisor does not meet the obligation to report. Retaliation in any form against an employee who reports a reasonable suspicion is strictly prohibited. The Facility will implement an abuse prohibition program through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and facility response to the results of their investigations.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of R3s face sheet showed his admission date was dated 04/24/24, his diagnoses included, Cognitive Communication Deficient, Congestive Heart Failure and Chronic Kidney Disease.</p> <p>Record review of R3s federally mandated quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 6/15 indicating R3 was cognitively impaired.</p> <p>Record review of R3s Care Plan initiated on 8/28/25 documented. R3 was dependent on staff to meet emotional, intellectual, physical, and social needs due to physical limitations.</p> <p>Record review of R3s progress notes dated 5/10/25 showed Licensed Practical Nurse (LPN) 5 documented, she was told GNA -9 used the "F" word to Resident R3 while providing care and documented GNA-9 was assigned to provide, R3 with Resident care. GNA-9 stated, she will not be fucking stressed out. R3 stated, he asked GNA-9 for oatmeal and GNA-9 said kiss my" ASS", LPN 5, notified the supervisor and the Director of Nursing (DON).</p> <p>Record review of a written statement dated 5/10/25, GNA-9 documented, she was in the room with two residents when R3 asked for a boiled egg, and his/her roommate asked for oatmeal. According to GNA-9, R3 kept saying things to her and she began to argue with R3 and told R3, "Fuck You", and the argument continued and documented she spoke out of anger.</p> <p>Record of a written statement dated 5/10/25, GNA 4 documented on 5/10/25 she was getting ready for Resident care, when breakfast trays were brought to the floor. DD then asked GNA-9 to help with passing out trays. GNA-9 refused to help her and went to R3s room and stayed there. GNA 4 later overheard GNA-9 shouting "Fuck Yourself" when R3 asked for cereal. GNA 4 wrote, GNA -9 always used curse words and did not always listen to instructions.</p> <p>Record review of a written statement dated 5/10/25, LPN 5 documented she instructed GNA-9 for help with breakfast trays. LPN -5 wrote GNA-9 did not do what she told her to do; GNA- 9 continued with patient care. Later, R3 asked GNA-9 for oatmeal and she stated she did not give R3 breakfast and whomever gave R3 breakfast should give him oatmeal.</p> <p>During an interview on 8/22/24 at 10:05 AM, LPN 5 revealed she was the charge nurse on 5/10/25 and she supervised GNA-9. LPN 5 stated R3 asked GNA-9 for cereal. According to LPN 5, GNA-9 then said, "kiss my ass", "fuck you". LPN 5 explained R3 had cognitive impairment, and she concluded, GNA-9 verbally abused R3 and should have never used derogatory comments.</p> <p>During an interview on 8/22/24 at 10:15 AM, GNA-4 stated on 5/10/25 she was the head GNA on duty and was working with GNA-9 she explained at approximately 7:00 AM GNA-9 refused her orders and went into R3s room and stayed there. Later on, she heard GNA-9 shouting at R3 and his/her roommate. According to GNA-4, GNA-9 told R3 "Fuck yourself" and used the F-word multiple times. GNA-4 stated she reported the abuse to LPN-5.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/25/25 at 8:30 AM GNA &amp;ndash;9 revealed she was on duty on 5/10/25 and she explained at approximately 7:30 AM her supervisor instructed her to assist too many Residents at the same time. She stated it was a bad day for her and added she was overly stressed. She explained R3 started demanding too many breakfast choices and she got upset with R3 when R3 continued to talk back to her. She stated she told R3, &amp;ldquo;Fuck You&amp;rdquo;. According to GNA-9, she did not understand that was not the correct way to respond at the time and concluded she should have walked out of R3s room.</p> <p>During an interview on 8/22/25 Administrator (A)1 revealed verbal abuse was not permitted and explained GNA 9's choice of words were verbal abuse and were not acceptable.</p> <p>During an interview on 8/22/25 at 2:15 PM the Regional Director of Nursing (RDON) 8 revealed GNA 9s conduct while she provided care was not in accordance with facility policy and was considered verbal abuse. She stated the facility in serviced all staff and the GNA-9 was terminated immediately.</p> <p>During an interview on 8/22/25 at 4:15 PM the Regional Nursing Consultant (RNC) 2 revealed abuse of any kind was not tolerated and she explained GNA-9 verbally abused R3 and her behavior was not acceptable.</p>		