STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215108	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doctors Community Rehabilitation and Patient Care	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #18) of 5 residents reviewed for a fall during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 4/15/26 at 7:10 AM a review of Resident #18's medical record was conducted and revealed Resident #18 had a fall on 1/18/26 at 13:45 (1:45 PM). Resident #18 sustained a hematoma and was sent to the emergency room for evaluation.Review of Resident #18's quarterly MDS with an assessment reference date (ARD) of 4/2/26, Section J, falls, failed to capture the fall of 1/18/26. On 4/15/26 at 11:00 AM an interview was conducted with the MDS Coordinator who stated that the person that did the MDS was not working today. The MDS Coordinator confirmed the error and stated she would do a correction.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 medical record review and interview, the facility failed to follow standard of practice during the care of the resident. This was evident for 1 (Resident #31) out of 3 residents reviewed for activation of emergency services during a complaint survey.The findings include: MOLST (Medical Orders for Life-Sustaining Treatment) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation (CPR) and other life-sustaining treatments. The medical orders are based on a resident and/or health care agent's directions about medical treatments. Review of Resident #31's medical record on [DATE] revealed the Resident was admitted to the facility in 2023. Further review of Resident #31's medical record revealed a MOLST dated [DATE] that stated the Resident was an Attempt CPR. Review of Nursing Supervisor #10's nurse's note for Resident #31 on [DATE] at 6:37 AM stated: 1 AM- The nurse on duty notified the nursing supervisor of the resident has become unresponsive and has no palpable pulse via telephone. 1 AM- CPR (Cardiopulmonary Resuscitation) and ventilations initiated. 1:05 AM- Resident's responsible party called and made aware of ongoing CPR efforts. Responsible party verbalized wishes to continue current advanced directives of full code. 1:05 AM On call provider notified of resident's change in condition. Verbalized to continue CPR and notify 911. 1:10 AM- 911 called to facility. 1:15 AM- 911 on site at facility, CPR maintained. 1:23 AM CPR efforts terminated and resident pronounced deceased by EMT/Paramedic on site. During interview with Nursing Supervisor (NS) #10 on [DATE] at 6:35 AM, NS #10 stated he received a call from LPN (Licensed Practical Nurse) #9 on [DATE] that Resident #31 was unresponsive. NS #10 stated he went to the Resident's room and staff were performing CPR. NS #10 was asked why he called the family first. NS #10 stated he left the room to call the family to update them and make sure that is what they wanted because the Resident looked pretty bad. NS #10 stated they did and then he called the on-call provider who told him to continue CPR and call 911. NS #10 stated he then called 911 and they were here quickly because they are right down the road. NS #10 stated EMS (Emergency Medical Services) took over CPR and pronounced the Resident deceased . NS #10 stated CPR did not stop until EMS pronounced the Resident. NS #10 was asked if an AED (Automated External Defibrillator) was placed by the facility staff and NS #10 stated yes but it said, shock not advised. Review of the EMS report for Resident #31 on [DATE] revealed it stated 911 was called on [DATE] at 1:16 AM, EMS arrived on the scene at 1:21 AM and the Resident was pronounced at 1:23 AM. The Report states the patient is in bed in cardiac arrest, skin is cold and rigor mortis has begun to set in. The Report also states staff of the nursing home have been providing CPR with an AED, but it did not advise a shock. Review of the facility's CPR policy dated [DATE] revealed it states: If a patient does not have a DNR (Do not resuscitate) order, CPR certified staff will initiate CPR and emergency medical services (EMS) will be activated. Review of the AHA (American Heart Association)'s 2025 guidelines for CPR revealed the following steps: check for responsiveness, shout for nearby help, activate emergency response system, send someone to get AED/defibrillator, for no breathing or no pulse start CPR. Interview with the Director of Nursing, Market Lead Clinical Specialist and Administrator on [DATE] at 1:10 PM confirmed the facility staff failed to call 911 prior to calling the Resident's representative and on call provider on [DATE] for Resident #31 per standards of practice.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review and interview, the facility staff failed to administer and hold medications as ordered by the physician . This was evident for 3 (Resident #31, #24 and #20) of 36 residents reviewed during a complaint survey.The findings Include: 1.The facility staff failed to administer a medication as ordered by the physician to Resident #31. Review of Resident #31's medical record on 4/9/26 revealed the Resident was admitted to the facility in 2023 with a diagnosis to include heart failure. Further review of the Resident's medical record revealed the was sent to the emergency room on 2/27/26 for abnormal labs. On 2/28/26 the Resident was followed up by Nurse Practitioner (NP) #24 who ordered to increase the Resident's Lasix from 20 mg to 40 mg daily for 7 days. Lasix is a medication used to treat fluid retention that can be caused by heart failure. Review of Resident #31's February and March 2026 Medication Administration Records revealed the Resident was administered Lasix 40 mg for 7 days through 3/6/26 but the facility staff failed to resume Resident's Lasix 20 mg on 3/7/26. The facility staff resumed administering Lasix 20 mg on 3/8/26, therefore the Resident missed one dose of Lasix 20 mg on 3/7/26. Interview with the Administrator on 4/16/26 at 12:05 PM confirmed the facility staff failed to administer Lasix 20 mg to Resident #31 on 3/7/26. 2) On 4/14/26 at 7:36 AM a review of Resident #24's medical record was conducted and revealed Resident #24 was admitted to the facility in June 2022 with diagnoses that included cerebral infarction (stroke) and hypertension. Review of Resident #24's physician's orders revealed Resident #24 was prescribed the medication Amlodipine Besylate 10 milligrams (mg) every day since 4/26/23 for hypertension (high blood pressure). The physician order stated to hold the medication if the SBP (systolic blood pressure), which was the top number on the blood pressure reading, was less that 110 and/or if the heart rate was less than 60 beats per minute. Review of Resident #24's April 2026 Medication Administration Record (MAR) documented on 4/4/26 Resident #24's heart rate was 52 and on 4/5/26 the heart rate was 54. The medication was administered by Licensed Practical Nurse (LPN) #26. The medication was administered outside of physician ordered parameters. Review of Resident #24's February 2026 MAR documented on 2/13/26 the heart rate was 51 and was administered by LPN #27. On 2/21/26 the heart rate was 59 and on 2/22/26 the heart rate was 55. The medication was administered by LPN #26. The medication was administered outside of physician ordered parameters. Review of Resident #24's January 2026 MAR documented on 1/13/26 the heart rate was 50 and on 1/14/26 the heart rate was 56. The heart rate was administered by LPN #27. The medication was administered outside of physician ordered parameters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's December 2025 MAR documented on 12/18/25 the heart rate was 56 and was administered by LPN #28. On 12/29/25 the heart rate was 55 and the medication was administered by LPN #27. The medication was administered outside of physician ordered parameters. Review of Resident #24's care plan, exhibits or is at risk for cardiovascular symptoms or complications related to TIA (Transient Ischemic Attack), CVA (stroke), uncontrolled HTN (hypertension), that was initiated on 6/24/22, documented the interventions, assess and monitor vital signs as ordered and report abnormalities to physicians; monitor apical heart rate. Review of nursing notes failed to produce documentation that the medication was held and the physician was notified. On 4/16/26 at 10:35 AM an interview was conducted with the Director of Nursing (DON). The concern related to the administered medication outside of physician ordered parameters was discussed. The DON agreed that it was a concern, and she stated that she would, look into it. On 4/16/26 at 11:43 AM LPN #23 was interviewed and stated he would look into the issue and agreed that the medication should have been held, and the physician should have been notified. On 4/16/26 at 1:09 PM the DON confirmed the surveyor's concerns related to the physician ordered parameters not being followed. The DON stated that they needed to start immediate education. 3) On 4/14/26 at 11:24 AM a review of Resident #20's medical record was conducted and revealed Resident #20 was admitted to the facility in January 2026 with diagnoses that included diastolic (congestive) heart failure and supraventricular tachycardia. Review of Resident #20's physician's orders revealed the medication Metoprolol Tartrate 25 mg., give 1 tablet 2 times per day for hypertension. The physician's order stated to hold for SBP below 110 or heart rate below 60 beats per minute. Review of Resident #20's February 2026 MAR documented on 2/1/26 at 9:00 AM the blood pressure was 106/66. The systolic number was below 110, however the medication was administered by LPN #7. On 2/4/26 at 9:00 AM the blood pressure was 99/57. The systolic number was below 110, however the medication was administered by Registered Nurse (RN) #30 (Agency nurse). The medication was administered when it was outside of physician ordered parameters. Review of Resident #20's January 2026 MAR documented on 1/9/26 at 9:00 PM the blood pressure was 109/68. The systolic number was below 110, however the medication was administered by LPN #29. The medication was administered when it was outside of physician ordered parameters. Review of Resident #20's care plan, at risk for cardiovascular symptoms or complications related to diagnosis of hypertension had the intervention, administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician. Review of nursing notes failed to produce documentation that the medication was held and the physician was notified. On 4/16/26 at 7:55 AM an interview was conducted with LPN #7. LPN #7 was asked if there were parameters for a SBP below 110 and the blood pressure was 106/66 would she give the medication or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hold it. LPN #7 stated said she would hold it. LPN #7 was shown the February MAR for 2/1/26 with her initials that the medication was given. LPN #7 stated, how could I do that. I will tell you that if the blood pressure is recorded you can't change it, but I do take the blood pressure before giving the med. But it is documented that way so I can't say. On 4/16/26 at 10:35 AM the issue with the medication given outside of the parameters was discussed with the DON and she agreed that it was a concern. On 4/16/26 at 1:09 PM the DON confirmed the surveyor's concerns related to the physician ordered parameters not being followed. The DON stated that they needed to start immediate education.