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	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doctors Community Rehabilitation and Patient Care	6710 Mallery Drive Lanham, MD 20706

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record reviews and interviews, it was determined that the facility failed to code the resident's status accurately on the Minimum Data Set assessment (MDS). This was evident for 1 (Resident #8) out of 2 residents reviewed for accuracy of assessments during the annual survey. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 12/04/2025 at 8:16 AM A review of Resident #8's medical records was conducted. The review revealed that Resident #8 was admitted into the facility on 4/13/2009, however, a medical diagnosis of Schizophrenia was created on 9/6/2023. On 12/05/2025 at 10:09 AM Further review of the resident's MDS was conducted. MDS assessment completed on 5/29/25, under section I, Active Diagnosis, the resident was not coded for schizophrenia, however, the MDS completed on 8/28/25 revealed that the resident was coded for schizophrenia. On 12/05/2025 at 11:46 AM The facility was asked to provide supporting documentation for coding schizophrenia on 8/28/25. On 12/05/2025 at 12:23 PM An interview with MDS coordinator, Staff #3, was conducted. She also brought documentation that stated Resident #8 was evaluated on 8/18/25 for antibiotic management consult. The provider documented past medical history that included schizoaffective disorder. Staff #3 acknowledged that there were no psychiatric notes or other documentation that indicated the resident had schizophrenia. She reported that another MDS coordinator, Staff #4, inaccurately coded for schizophrenia and that the schizophrenia diagnosis should not have been coded. Staff #3 stated that she would amend the MDS. On 12/08/2025 at 9:59 AM Further review of Resident #8's medical records revealed that the schizophrenia diagnosis was removed from the resident's medical history. Additionally, the MDS was modified to remove Schizophrenia on 12/5/2025. On 12/08/2025 at 12:21 PM The facility administrator and Director of Nursing (DON) were made aware of the concerns.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and record reviews, it was determined that the facility failed to update a resident's care plan to reflect individualized preferences. This was evident for 1 (Resident #6) out of 7 residents reviewed for care plan development during the annual survey.The findings include:On 12/03/2025 at 9:38 AM An interview with Resident #6's Representative was conducted. They reported that they have communicated to the facility that they preferred only female providers to care for Resident #6. However, there was a day in which the Resident Representative found a male staff caring for the resident. On 12/10/2025 at 10:10 AM A review of Resident #6's medical record was conducted. The review failed to show any documentation of the resident's female preference for provision of care. On 12/10/2025 at 10:14 AM An interview with Staff #6 was conducted. When asked if she was aware of Resident #6's preference, she said yes, that the resident preferred only female Geriatric Nursing Assistants (GNAs) to care for them. She also added that the preferences are documented on the care plan. On 12/10/2025 at 10:46 AM An interview with the unit manager, Staff #10, was conducted. When asked where a resident's preference for female GNAs would be documented, he reported that the preferences should be in the resident's care plan. A review of Resident #6's care plan was done with the surveyor and the staff. The care plan did not have the preferences documented. On 12/10/2025 at 10:55 AM An interview with the facility's administrator was conducted. She stated that if a resident prefers female staff, it's the facility's policy to document the preference in the care plan. On 12/10/2025 at 12:08 PM A brief interview with the Director of Nursing (DON) was conducted. She confirmed that it is the facility's process to update the care plan if a resident prefers only female GNAs, and that the care plan and tasks were not updated to reflect the gender preference for Resident #6.On 12/10/2025 at 12:18 PM The facility administrator and DON were notified of the failure to update the care plan concerns.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews, it was determined that the facility failed to administer medications in a timely manner. This was evident for 1 (Resident #128) out of 1 residents reviewed for medication administration during the complaint survey. The findings include: On 12/10/2025 at 1:00 PM A review of the complaint # 2624858 submitted to the Office of Health Care Quality (OHCQ) was conducted. The review alleged that Resident #128 was not given their morning medications on 6/13/2025. On 12/10/2025 at 1:25 PM An interview with the complainant was conducted. The complainant stated that Resident #128 reported that they were not given medications and vital signs were never obtained on 6/13/2025. On 12/11/2025 at 9:14 AM A review of Resident #128's medical record was conducted. The review revealed a Situation, Background, Assessment Recommendation (SBAR) note dated 6/13/2025, that reported the resident was never given morning medications. A review of June 2025 Medication Administration Record (MAR) failed to show that medications were administered the morning of June 13th, 2025. The following medications were not administered as ordered: Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for Edema Folic Acid Oral Tablet 1 MG (Folic Acid) Give 1 tablet by mouth one time a day for Supplement Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for Supplement Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet by mouth two times a day for Constipation Amlodipine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for High blood pressure (HTN) Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 1 tablet by mouth one time a day for Arrhythmia Losartan Potassium 100 MG TAB Give 1 tablet by mouth one time a day for HTN Metformin HCl Oral Tablet 1000 MG (Metformin HCl) Give 1 tablet by mouth one time a day for Diabetes Before breakfast Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gabapentin Oral Tablet 600 MG (Gabapentin) Give 1 tablet by mouth every 8 hours for Neuropathy. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours for Pain On 12/11/2025 at 10:56 AM An interview with Staff #14 was conducted. When asked what the facility's expectation was for medication administration and documentation, she stated that nurses are required to sign off medications immediately after the medication is given to a resident. The facility staff is expected to document why a medication is not given to a resident, such as refusals or if a resident is out of the facility. On 12/11/2025 at 11:22 AM An interview with the Director of Nursing (DON) was conducted. Per DON, the medication error incident was submitted to OHCQ on 6/13/25. She further stated that the facility was able to substantiate that Resident #128 was not given their medications as ordered on 6/13/2025. On 12/11/2025 at 12:02 PM Further review of the facility's incident report revealed a note that stated on 6/13/2025, the nurse assigned to Resident #128 had a rough day, the medication cart was not organized, and the nurse spent a lot of time looking for medications. On 12/11/2025 at 1:32 PM A follow-up interview with the DON was conducted. She stated that the nurse who was assigned to care for Resident #128 on 6/13/2025, refused to provide a statement of what happened that day that led to some residents not receiving medications. On 12/11/2025 at 1:38 PM The Administrator and DON were notified of the medication error concern.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observations, interviews and record reviews, it was determined that the facility failed to provide dental health evaluation and services to the residents. This was evident for 2 (Resident #15 and #10) out of 4 residents evaluated for dental health. The findings include: 1.) On 12/03/2025 at 8:28 AM An observation and interview were conducted. Resident #15 was observed with missing teeth on the bottom of the mouth. When asked if they had dentures, Resident #15 stated that they had the top plate, but the bottom plate was lost. On 12/08/2025 at 12:33 PM A review of Resident #15's medical record was conducted. The review revealed that the resident had an oral health evaluation completed on 6/9/23 that indicated the resident had lower dentures. On 12/08/2025 at 12:40 PM An interview with Staff #13 was conducted. She reported that she had never seen Resident #15 with dentures. On 12/08/2025 at 1:56 PM An interview with the Director of Nursing (DON) was conducted. She reported that Resident #15 had upper dentures only and that the facility's dentures documentation was inaccurate, that is, the resident did not have lower dentures. The DON was asked what the facility's policy was on conducting routine dental services for residents, the DON replied that she would verify and provide the oral health policy. On 12/09/2025 at 9:20 AM The facility provided the oral health policy. Review of this policy revealed that residents' oral health was to be evaluated routinely, annually and as needed. On 12/09/2025 at 11:16 AM Staff #2 provided documentation of oral health assessment completed after surveyor's intervention that noted Resident #15 had several missing teeth and decayed teeth were noted on the lower jaw. On 12/09/2025 at 1:50 PM An interview with the DON was conducted. She confirmed that Resident #15's last oral health assessment was completed on 6/9/2023. DON reported that the facility was in the process of scheduling a dental visit for Resident #15. 2.) On 12/03/2025 at 10:18 AM An observation and interview were conducted. Resident #10 was observed with missing teeth, and they also reported that they've had occasional tooth pain. On 12/08/2025 at 9:24 AM A review of Resident #10's medical record was conducted. The review revealed a note entered on 8/21/2025 at 9:39 AM by Nutrition Staff that stated the resident complained of tooth pain and sore gums. According to the note, the nursing staff was aware, and a dental appointment was pending. Moreover, there was another progress note dated 8/16/25 that indicated the resident was evaluated because they complained that their mouth was sore. The note stated, dental consult for oral abscess, appointment scheduled for Monday 8/25/25. A review of the resident's records revealed an order that stated to consult with dental for treatment as needed for patient health and comfort. On 12/08/2025 at 10:10 AM Further Review of Resident #10's medical chart failed to show that the resident was evaluated by a dentist. The facility was asked to provide evidence for dental services provided for the resident in 2025. On 12/08/2025 at 11:17 AM An interview with the administrator and Staff #2 was conducted. They both confirmed that there was no evidence that the resident left the facility for the 8/25/25 dental appointment. On 12/08/2025 at 11:29 AM Another follow up interview with Staff #2 was conducted. She reported that she had added an order for dental consultation for the resident to be seen on 12/9/2025. On 12/09/2025 at 9:42 AM The facility provided Resident #10's oral health evaluation that was completed on 1/16/2024. Staff #2 confirmed that there was no evidence that the resident had an oral health assessment completed in 2025. On 12/09/2025 at 1:52 PM The facility administrator and DON were notified of the oral health concerns identified.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interviews and medical record review, it was determined the facility failed to follow up with neurologist consultation recommendations which resulted in a delay of care for the resident. This was evident for 1 (Resident #109) of 1 resident reviewed for use of outside sources during the survey. The findings include: On 12/03/2025 at 10:14 AM, during an interview with Resident #109, they stated that they were having a concern with a vibration feeling in their left ear. They stated that they were seeing a neurologist, but had not been seen for about eight months. On 12/08/2025 at 10:33 AM, a review of a neurologist consult from 5/13/25 revealed recommendations for the resident to obtain an electroencephalogram (EEG), the EEG results report to be faxed when it is completed, and that there would be a follow up appointment after reviewing the results. An EEG (electroencephalogram) is a painless, non-invasive test that records your brain's electrical activity using sensors (electrodes) placed on your scalp, showing brain waves as wavy lines to help diagnose conditions like epilepsy, sleep disorders, brain tumors, or confusion from head injuries, providing crucial info on brain function that structural scans miss. On 12/08/2025 at 10:34 AM, a review of resident medical records for orders, revealed that an EEG had been ordered and marked completed on 6/8/2025. On 12/08/2025 at 10:35 AM, a review of progress notes revealed a nursing note from 6/16/2025 at 3:02 PM that stated, Resident went to the EEG appointment with his/her sister at 9 am and came back at 2:30 PM. On 12/09/2025 at 12:36 PM, during an interview with the Director Of Nursing (DON), she stated that they were able to locate the results of the EEG but were not able to find if the results had been sent to the neurologist following the results. At this time the concern for the delay in care was brought to the DON's attention. The Neurologist office was waiting for the EEG results in order to make a follow up appointment for the resident. The resident had not been seen since prior to the EEG being completed. On 12/10/2025 at 9:37 AM, during an interview with the administrator, she stated that she was not sure what happened but the results of the EEG were never sent to the neurologist. She stated that her expectation is that when diagnostic tests are completed, they will send the results immediately to where they need to go.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observations, and staff interviews, it was determined that the facility failed to follow appropriate infection control practices. This was evident for 2 (Resident #4 and #6) out of 33 residents reviewed during the recertification survey.The findings include:Enhanced Barrier Precautions (EBP), are infection control guidelines for nursing homes, recommended by the Centers for Disease Control and Prevention, to stop the spread of dangerous antibiotic-resistant germs by requiring gowns and gloves only for high-contact care (bathing, dressing, wound care, device care) for residents with wounds, devices, or known multi-drug-resistant organisms. 1) On 12/09/2025 at 11:21 AM A review of Resident #6's medical records was conducted. The review revealed that the resident had a pressure ulcer on the sacrum that required daily dressing change. There was an order that indicated EBP should be followed during wound care. On 12/09/2025 at 11:33 AM An observation of Resident #6's wound care was conducted. Assisting with the wound care procedure was Staff #7 (Wound Team Lead) and Staff #6. Staff #6 was observed wearing gloves only, no gown. On 12/09/2025 at 11:40 AM Staff #7 was observed removing the dirty dressing. She then cleaned the wound, removed the gloves and wore clean gloves to apply a clean dressing to the wound. No hand hygiene was performed. On 12/09/2025 at 12:00 PM An interview with Staff #7 was conducted. When asked why she did not perform hand hygiene before wearing clean gloves and applying a clean dressing, she replied that she was taught that unless the gloves were visibly soiled, one does not have to clean her hands before wearing clean gloves. On 12/09/2025 at 12:23 PM An interview with Staff #6 was conducted. She acknowledged that she forgot to wear a gown as indicated on the EBP order because she was in a rush. On 12/09/2025 at 12:33 PM Further review of the facility's dressing change procedure instructions revealed that the staff should perform hand hygiene after removal of dirty dressing and before wearing clean gloves to apply clean dressing. On 12/09/2025 at 1:57 PM The Director of Nursing (DON) and administrator were made aware of the infection control concerns identified. 2) On 12/11/2025 at 10:05 AM, a review of Resident #4 records and the facility's Infection Surveillance Monthly report for November 2025 was conducted. Resident #4 had a red stop sign in their Electronic Health Record (HER) profile. The Infection Surveillance report shows that the resident had Clostridium difficile and a Wound infection, both of which had been resolved. Resident #4 had active/open wounds with wound care orders according to their medical record. On 12/11/2025 at 10:09 AM, an observation of the 100 unit and Resident #4's room was made. No signage on door or inside room stating the resident was on EBP was seen. A Personal Protective Equipment (PPE) cart was seen across hallway. On 12/11/2025 at 10:19 AM, an interview with the Infection Preventionist (IP) was conducted. When (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked about if Resident #4 had any active infections, the IP stated that they do not have any current infections. When asked why the resident has a Red Stop sign in their EHR profile, the IP stated that this was a precaution that the resident was still susceptible to infection because of the history of infection and active wounds. When asked if there should be something on the Resident's door or entrance to notify staff and visitors of EBP for the resident, the IP stated yes but staff also is aware of the precaution because of the sign in the EHR. On 12/11/2025 at 10:42 AM, an interview with the DON was conducted. When asked what is used to make staff and visitors aware that a resident is on EBP, The DON stated that there should be signage on the door that states EBP, a red stop sign in the resident's electronic health record, and a PPE cart adjacent to the room. When asked if there would be a case that the sign is not on the door and the red sign in the EHR, the DON stated no they should both be there. When asked who is in charge of placing signs on the door, the DON stated that the unit manager oversees it for their unit and the IP provides oversight ensuring the appropriate residents have the correct signage.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record review, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests. This was evident in the kitchen during the initial kitchen tour. The findings include: On 12/03/2025 at 8:43 AM, an observation was made during the initial kitchen tour. A small brown insect was observed crawling on kitchen wall by hand wash sink near the walk-in Refrigerators. On 12/03/2025 at 9:11 AM, a surveyor conducted an interview with Resident #6's representative. They reported that they had observed roaches in the resident's room. On 12/04/2025 at 12:05 PM, an interview was conducted with the Maintenance director (Staff #1). When asked if the facility had any issues with pest control, Staff #1 stated that any issues will be reported directly to the pest control company and the facility keeps copies of their reports. This surveyor made Staff #1 aware of the surveyor's insect sighting in the kitchen.