STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215264	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larkin Chase Center	15005 Health Center Drive Bowie, MD 20716

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to protect residents private information during medication administration. This had the potential to affect 14 of 73 residents information.During observation on 2/19/26, a medication cart was observed between rooms [ROOM NUMBERS] from 9:55 am until 9:59 am, with the Electronic Health Records visible on the computer screen for 14 of 73. Several visitors and staff members were seen walking along the hallways past the medication cart. Licensed Practical Nurse (LPN) 23 walked out of room [ROOM NUMBER], approached the medication cart, and locked it, but did not close the Electronic Health Records (EHR).During the interview on 2/19/23 at 9:59 am, LPN #23 confirmed s/he was the nurse responsible for the medication cart and that s/he had left the EHR visible, with resident information displayed.During the interview on 2/19/23 at 10:04 am, the Director of Nursing (DON) stated that the expectations are for nursing staff to protect residents' personal health information and that the EHR should not be visible to passersby.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of facility policy titled 'Medication Storage-Storage of Medications', the facility failed to ensure 1 of 4 medications carts was locked when not in use.Review of facility policy titled 'Medication Storage-Storage of Medications' dated 01/25 revealed 'Procedures 3. To limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medication (such as medication aides) may access medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by people with authorized access.'During observation on 2/19/26, a medication cart was observed between rooms [ROOM NUMBERS], unlocked and unattended from 9:55 am until 9:59 am. Several visitors and staff members were seen walking along the hallways past the medication cart. Licensed Practical Nurse (LPN) 23 walked out of room [ROOM NUMBER], approached the medication cart, and locked it.During the interview on 2/19/23 at 9:59 am, LPN #23 confirmed s/he was the nurse responsible for the medication cart and confirmed s/he had left the medication cart unlocked and unattended. Stated s/he knew the cart should be locked when not attended.During the interview on 2/19/23 at 10:04 am, the Director of Nursing (DON) stated that the expectation is for nurses to lock the carts when they are not in direct line of sight, and that nurses are aware of this policy.