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	04/14/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain consent prior to the use of psychotropic medications for 2 (Resident #6 and Resident #7) of 14 sampled residents. The findings included: 1. A Face Sheet revealed the facility admitted Resident #6 on 02/02/2026. According to the Face Sheet, the resident had a medical history that included diagnoses of anxiety disorder and primary insomnia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident used an antianxiety medication during the last seven days. Resident #6's Care Plan Report included a focus area initiated 02/11/2026, that indicated the resident was at risk for complications related to the use of psychotropic drugs. Interventions directed staff to provide informed consent to resident or healthcare decision maker (initiated 02/11/2026). Resident #6's Order Recap Report for the timeframe 02/01/2026 - 03/31/2026, revealed an order dated 02/04/2026, for clonazepam oral tablet 0.5 milligram (mg), give one tablet by mouth one time a day for anxiety; this order was discontinued on 03/09/2026. Per the Order Recap Report, there was an order dated 03/09/2026, for clonazepam oral tablet 0.5 mg, give one tablet by mouth one time a day for anxiety. Resident #6's Medication Administration Record [MAR] for the timeframe 02/01/2026 - 02/28/2026 and 03/01/2026 - 03/31/2026, revealed the staff administered clonazepam to the resident as ordered. Resident #6's Psychotropic Medication Administration Disclosure located in the resident's medical record was blank. During an interview on 04/09/2026 at 12:46 AM, Registered Nurse #29 stated she knew psychotropic medications required consent prior to use and remembered Resident #6 could not sign their own consent but did not recall reviewing the psychotropic consent with the resident. During an interview on 04/03/2026 at 3:32 PM, Licensed Practical Nurse #30 stated psychotropic medications needed consent prior to use. During an interview on 04/13/2026 at 1:30 PM, the Director of Nursing confirmed that Resident #6 did not have consent for the psychotropic medication, and consent should have been obtained. During an interview on 04/13/2026 at 4:12 PM, the Administrator stated psychotropic medications required consent prior to use according to federal guidelines. 2. A Face Sheet revealed the facility admitted Resident #7 on 10/25/2025. According to the Face Sheet, the resident had a medical history that included diagnoses of major depressive disorder and primary insomnia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/01/2026 revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident used an antidepressant medication during the last seven days. Resident #7's Care Plan Report included a focus area initiated 11/03/2025 and revised 03/19/2026, that indicated the resident was at risk for complications related to the use of psychotropic drugs. Resident #7's Order Recap Report for the timeframe 10/01/2025 - 03/30/2026, revealed an order dated 12/07/2025, for escitalopram oxalate oral tablet 20 milligrams, give one tablet by way of the gastrostomy tube at bedtime for depression. Resident #7's Medication Administration Record [MAR] for the timeframe 03/01/2026 - 03/31/2026, revealed the staff administered escitalopram oxalate to the resident as ordered. Resident #7's Psychotropic Medication Administration Disclosure located in the resident's medical record was (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blank. During an interview on 04/13/2026 at 1:30 PM, the Director of Nursing confirmed the resident did not have consent for psychotropic medications and stated consent should have been obtained when the medication was started. During an interview on 04/13/2026 at 4:12 PM, the Administrator stated psychotropic medications required consent prior to use according to federal guidelines.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to promptly notify the provider of a critical and abnormal laboratory test values for 1 (Resident #7) of 3 sampled residents reviewed for a change in condition. On [DATE], Resident #7 experienced a change in condition and a nurse practitioner (NP) ordered STAT (a Latin word, statim, which meant immediately or without delay) laboratory tests to rule out pneumonia and assess for other possible underlying causes of the resident's change in condition. The blood specimen was collected for the laboratory tests, which revealed the resident had a high critical sodium level of 161 millimoles per liter (mmol/L). This critical laboratory value was communicated to the facility nursing staff on [DATE]; however, the provider was unaware of the results until [DATE]. After review of the resident's clinical status and laboratory test results, concern was expressed by the providers for the resident's deterioration and agreed the resident required transfer to the hospital for further evaluation and management at a higher level of care. Resident #7 was transferred to the local hospital around 11:30 AM. Resident #7 arrived at the hospital and was noted to be hypotensive (low blood pressure) with agonal respirations. Cardiopulmonary resuscitation (CPR) was initiated when the resident was noted not to have a pulse. The resident remained pulseless despite multiple rounds of CPR and expired at 12:38 PM on [DATE]. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 483.10 Resident Rights, F580, Notification of Changes at a scope and severity of J. The IJ began on [DATE] when the facility failed to promptly notify the provider of a critical and abnormal laboratory test values for Resident #7.The survey team notified the Administrator, Director of Nursing, and four clinical advisors of the IJ and provided the IJ template on [DATE] at 11:00 AM. A removal plan was requested. The facility's removal plan was accepted by the state survey agency on [DATE] at 8:34 PM. The IJ was removed on [DATE], after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F580 remained at a lower scope and severity of D, isolated/no actual harm with the potential for more than minimal harm.Finding included: A facility policy titled, NSG122 Change in Condition: Notification of, revised [DATE], specified: Policy A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: * An accident involving the patient which results in injury and has the potential for requiring physician intervention; * A significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); * A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or * A decision to transfer or discharge the patient from the Center. When making notification of above, the Center must ensure that all pertinent information is available and provided upon request to the physician. Purpose: To provide appropriate and timely information about changes relevant to the patient's condition. A Face Sheet indicated the facility admitted Resident #7 on [DATE]. According to the Face Sheet, the resident has a medical history that included atherosclerotic heart disease, paroxysmal atrial fibrillation, encephalopathy, vascular dementia, traumatic subdural hemorrhage, hypertension, and cognitive communication deficit. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #7's Progress Notes, written by NP #6 and dated [DATE] at 11:17 AM, revealed the NP was requested to evaluate the resident for acute respiratory distress. The Progress Notes indicated the resident had difficulty breathing with the use of their accessory (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	muscles, had lung crackles, and an oxygen saturation of 93-96% on room air. Per the Progress Notes, the NP ordered a treatment plan to include a STAT chest x-ray, STAT laboratory tests including a comprehensive metabolic panel (CMP), magnesium level, and a complete blood count (CBC) with differential to rule out pneumonia and assess for other possible underlying conditions.Resident #7's Order Details, revealed a physician's order dated [DATE] at 11:12 AM, for a STAT chest x-ray. Resident #7's Order Details, revealed a physician's order dated [DATE] at 11:15 AM, for a STAT CMP, magnesium level, and a CBC with differential. Resident #7's laboratory test result report revealed a blood specimen was collected from the resident on [DATE] at 5:11 PM for a CMP, magnesium level, and CBC with differential. Per the results, the resident's sodium level registered high critical at 161 mmol/L; the resident's blood urea nitrogen (BUN) registered high at 55 milligrams per deciliter (mg/dL); the resident's magnesium level registered high at 2.9 mg/dL; and the resident's white blood cell (WBC) count registered high at 29.68 10 cubed per microliter (uL). Resident #7's Progress Notes, written by NP #6 and dated [DATE] at 11:51 AM, revealed Patient was seen today for follow-up of ongoing acute respiratory distress for which stat laboratory tests, chest X-ray, and DuoNeb treatments were ordered yesterday [[DATE]] due to increased work of breathing and clinical decline. Results of the stat laboratory tests obtained today [[DATE]] were reviewed and showed significant abnormalities, including markedly elevated WBC of 29.68 BUN of 55 consistent with acute kidney injury, and severe hypernatremia with sodium of 161. These findings are concerning for worsening condition with dehydration, possible infection, and renal impairment. The patient was started on half-normal saline at 124 cc [cubic centimeters] per hours for a total of 2 liters for hydration and sodium correction. Patient assessed at bedside awake at time, lethargic and showing clinical decline. [His/Her] vital stable with blood pressure 127/75 heart rate 64 temperature 96.6 oxygen 97 on room air. The provider discussed the patient's condition and abnormal laboratory results with [Resident #7's Attending Physician], who was in house at the time of evaluation. After review of the clinical status and labs, he expressed concern for the patients deterioration and agreed that the patient requires transfer to the hospital for further evaluation and management at a higher level of care. Resident #7's Order Details revealed a physician's order dated [DATE] at 11:27 AM, that specified to transfer the resident to the nearest emergency room due to critical laboratory values and an elevated WBC count. Resident #7's Emergency Department Provider Note, dated [DATE], revealed Per EMS [emergency medical services], they were called to the patient's rehab facility due to decreased oxygen saturation. On arrival, patient was noted to be hypotensive [low blood pressure] with agonal respirations. EMS established IO [intraosseous] access and began giving fluids. They began bagging the patient and then patient lost pulses. CPR [cardiopulmonary resuscitation] was started at 11:55 AM. Patient received 4 doses of epinephrine. [Resident #7] was noted to be asystole on the monitor. Per the Emergency Department Provider Note, Patient remained pulseless and asystole with cardiac standstill on ultrasound despite multiple rounds of CPR and medications. Given this, decision was made to terminate resuscitation efforts. Time of death 12:38 PM. During a telephone interview on [DATE] at 3:10 PM, the laboratory vendor representative stated the laboratory vendor received an order for Resident #7 on [DATE] at 11:20 AM, the laboratory collected the blood specimen at 3:30 PM, and the results were reported to the Evening Nursing Supervisor at 8:57 PM on [DATE]. During an interview on [DATE] at 1:00 PM, the Evening Nursing Supervisor stated she did recall receiving a telephone call about Resident #7's critical and abnormal laboratory values. The Evening Nursing Supervisor stated she did not think it was her who the laboratory called. During an interview on [DATE] at 10:32 AM, NP #6 stated the facility should have contacted the provider when the critical laboratory test results came in. NP #6 stated had she been notified the evening of [DATE] when the resident's laboratory test results were received, she would have sent the resident to the hospital. During an interview on [DATE] at 11:06 AM, the Director of Nursing (DON) stated the nurses were responsible for reporting all critical laboratory values immediately. The DON stated when Resident #7's critical laboratory test results were received, the facility should have reported the results to the (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on-call provider. The DON confirmed she was unaware Resident #7's critical laboratory test results were not reported to the provider. During a telephone interview on [DATE] at 10:44 AM, the Medical Director (MD) stated the expectation was for providers to be notified immediately of all critical laboratory test results. According to the MD, he felt the outcome for Resident #7 would have been the same regardless of when the resident was sent to the hospital. During an interview on [DATE] at 4:12 PM, the Administrator stated he expected provider notification whenever there was a change in a resident's condition, including when critical laboratory test results were received. The facility submitted a removal plan that was accepted by the state survey agency on [DATE] at 8:34 PM. The removal plan indicated the following: F580 - Notification of Change: Removal PlanThis Plan of Removal is in response to the identification of Immediate Jeopardy communicated by the survey team on [DATE]. The facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Corrective Action Identification of residents affected or likely to be affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. Resident #7 is no longer at the facility; therefore, corrective action cannot be completed for this resident. Current residents with orders for laboratory values were reviewed by the DON and regional clinical nurses to ensure the following: (1) results were received (2) notification of results was communicated to the medical provider (3) results were reviewed by a medical provider (4) documentation of recommendations and/or new orders by medical provider after review of laboratory values were present in the electronic medical chart will be completed by [DATE] Current residents presenting with a change in condition, as per Policy NSG122 Change in Condition: Notification were reviewed by the DON and regional clinical nurses to ensure the following: (1) notification of change in condition to medical provider (2) new orders documented by [DATE]. On [DATE] at 6:44 PM, only three current residents presented a change in condition. Actions to prevent occurrence/reoccurrence:The facility took the following actions to prevent an adverse outcome from occurring. Steps for communication pertaining to critical laboratory values will be as follows:-The licensed nurse receiving the critical lab value will notify the covering physician of the lab values when results are received from the contracted lab.-Laboratory vendors will call the facility with critical lab results. If unable to reach a licensed nurse or medical provider within two hours, the call will be escalated to the DON and Administrator.-The DON and/or designee educated licensed nurses including agency nurses working on [DATE] on reporting laboratory results to the medical provider. Licensed nurses including agency nurses not working on [DATE] will be re-educated by [DATE]. The education will be added to the agency nurse's orientation packet and provided prior to the start of the first shift worked. During the daily clinical morning meeting, the DON and/or designee will notify the medical provider of unreviewed abnormal laboratory results and document the intervention in a progress note daily x3, weekly x4, then monthly x2. The Administrator will review the results of the audits in a weekly ad hoc quality assurance performance improvement (QAPI) to ensure compliance has been achieved and sustained. All corrections were completed on [DATE].The immediacy of the IJ was removed on [DATE]. The IJ was removed on [DATE] at 10:00 AM after the survey team verified the facility's implementation of the removal plan as follows: Step 1 - Review of all residents with pending or completed lab ordersRemoval Plan Action:The facility stated that leadership (including the DON and Market Clinical Lead) reviewed all residents with recent or pending lab results to confirm provider notification occurred and corrective interventions were in place. Survey Team Verification: The survey team reviewed a random sample of five residents from the lab review list. Records confirmed that abnormal lab values were reviewed by providers and corresponding orders were implemented. Interview with the Market Clinical Lead confirmed the audit process, provider notification, and documentation in progress notes. Step 2 - Daily Audits for Notification ComplianceRemoval Plan Action:The DON initiated daily audits to confirm timely provider notifications and correct documentation of abnormal findings across labs. Survey Team Verification: The survey team reviewed completed audits from [DATE] and [DATE]. Audits included checks for (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abnormal lab reporting and follow-up actions. Interviews with the DON confirmed audit findings were validated during daily clinical meetings, and escalation protocols were in place for discrepancies. Step 3 - Education to licensed nurses on change-in-condition and lab reportingRemoval Plan Action:The facility provided immediate education to licensed nurses (including agency staff) on:STAT order escalation and 4-hour thresholdAbnormal lab result notification Survey Team Verification:Education sign-in sheets were reviewed for sessions conducted on [DATE], with supplemental one-on-one in-services completed by [DATE]. Interviews with staff across all shifts confirmed correct understanding of: Step 4 - Process fix and QAPI integration for lab order workflowRemoval Plan Action:The facility implemented a reconciliation process to prevent lab integration errors (facility's determined root cause of initial IJ), requiring the night shift to compare the daily lab manifest against active order listings with results reviewed during the morning clinical meeting. Facility leadership also initiated ad hoc QAPI review of the IJ plan. Survey Team Verification: The survey team interviewed the Market Clinical Lead, who demonstrated the new workflow for lab manifest cross-checks and presented the QAPI minutes from [DATE], which documented the IJ plan of removal review. The team verified documentation of education, process updates, and ongoing monitoring mechanisms. The survey team validated through record review and interviews with nurses across all shifts plus the DON and the Market Clinical Lead, that the immediate jeopardy removal plan was fully implemented and systemic corrections were in place.

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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 interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of abuse to the state survey agency for 1 (Resident #5) of 8 sampled residents reviewed for abuse.Findings included: A facility policy titled, Abuse Prohibition, revised 11/14/2025, revealed, 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following 7.1 Enter allegation into PCC [Point Click Care] Risk Management Portal. 7.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two (2) hours after the allegation is made. A Face Sheet revealed the facility admitted Resident #5 on 12/04/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2026, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Facility Reported Incident [FRI] Initial Report Form submitted by the Administrator and dated 03/19/2026, indicated on 03/19/2026 at 9:30 AM, the Director of Nursing notified the Administrator of an allegation of sexual abuse alleged by Resident #5. Per the FRI Initial Report Form, Housekeeper #2 alleged she saw Housekeeper #1 enter Resident #5's room and hug and kiss the resident. According to the FRI Initial Report, this allegation of abuse was reported to the state survey agency on 03/19/2026 at 12:13 PM. During an interview on 04/02/2026 at 1:41 PM, the Administrator stated his expectation was that any allegation of abuse must be reported immediately.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, document review, and facility policy review, the facility failed to ensure staff assigned to care for a resident was interviewed once the resident voiced an allegation of neglect for 1 (Resident #1) of 8 sampled residents reviewed for abuse.Findings included: A facility policy titled, OPS300 Abuse Prohibition, revised 11/14/2025, indicated 7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 7.7.1 whether abuse or neglect occurred and to what extend; 7.7.2 clinical examination for signs of injuries, if indicated; 7.7.3 causative factors; and 7.7.4 interventions to prevent further injury. 7.8 The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included. A Face Sheet revealed the facility admitted Resident #1 on 07/02/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The undated Facility Reported Incident [FRI] Follow-Up Investigation Report Form completed by the Director of Nursing (DON) indicated on 02/14/2026 and 02/15/2026, Resident #1 stated they were left in bed without a bath or assistance, a female geriatric nurse aide (GNA) was rough when she provided care to them, and their call light was turned off. The facility investigation file contained statements from two registered nurses and GNA #5. The facility staffing assignments revealed GNA #10 was assigned to Resident #1 on 02/13/2026 and 02/14/2026 during the 11:00 PM to 7:00 AM shift, and GNA #13 was assigned to Resident #1 during the 11:00 PM to 7:00 AM shift on 02/15/2026. During an interview on 04/03/2026 at 10:49 AM, Resident #1 stated the incident occurred during the 11:00 PM to 7:00 AM shift and they could not remember the employee's name. During an interview on 04/06/2026 at 4:26 PM, the DON stated during an investigation the facility typically interviewed the primary care staff assigned to the resident at a minimum. During an interview on 04/06/2026 at 4:43 PM, the Administrator stated abuse investigations should be thoroughly investigated to determine the thoroughness of the investigation.

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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. Based on interview, record review, and document review, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) for 1 (Resident #9) of 3 sampled residents reviewed for pressure ulcer/injury. Findings included: On 04/14/2026 at 8:59 AM, Clinical Advisor #32 stated the facility did not have a policy regarding completion of the MDS; however, they followed the Resident Assessment Instrument manual. The Centers for Medicare & Medicaid Services Long-Term Care [LTC] Facility Resident Assessment Instrument [RAI] 3.0 User's Manual dated 10/2024, indicated If the medical record reveals that the resident currently has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries. Per the LTC Facility RAI 3.0 User's Manual, Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) n the 7-day look-back period. A Face Sheet indicated the facility admitted Resident #9 on 08/05/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side. A quarterly MDS, with an Assessment Reference Date (ARD) of 02/17/2026, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was not at risk of developing pressure ulcers/injuries and had no unhealed pressures ulcers/injuries. Resident #9's Care Plan Report included a focus area initiated 08/07/2025, that indicated the resident was at risk for skin breakdown related to incontinence, limited mobility, and a pressure ulcer on their right gluteus/sacral area, left heel, and left lateral ankle. Resident #9's Progress Notes electronically signed by the Wound Physician and dated 01/28/2026, indicated the resident had an unhealed Stage 3 pressure ulcer on their sacrum. Resident #9's Progress Notes completed by the Evening Nursing Supervisor and dated 02/12/2026, indicated the resident had an in-house acquired Stage 3 pressure ulcer on their left gluteus. During an interview on 04/13/2026 at 8:33 AM, the Director of Nursing reviewed Resident #9's quarterly MDS with an ARD of 02/17/2026 and confirmed the presence of the resident's pressure ulcer was not coded but it should have been coded. During an interview on 04/13/2026 at 12:17 PM, the MDS Coordinator stated the accuracy of the MDS was important so the facility could get a good, full picture of the resident. The MDS Coordinator confirmed she missed coding Resident #9's Stage 3 pressure ulcer on the quarterly MDS with an ARD of 02/17/2026. During an interview on 04/13/2026 at 4:12 PM, the Administrator stated it was important for the MDS to be accurate because it gave an accurate representation of a resident's status. The Administrator stated if a resident had a Stage 3 pressure ulcer, he would expect it to be reflected on the resident's MDS.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a STAT (a Latin word, statim, which meant immediately or without delay) chest x-ray was completed as ordered and timely provider notification of a critical and abnormal laboratory test values for 1 (Resident #7) of 3 sampled residents reviewed for a change in condition. On [DATE], Resident #7 experienced a change in condition and a nurse practitioner (NP) ordered a STAT chest x-ray and STAT laboratory tests to rule out pneumonia and assess for other possible underlying causes of the resident's change in condition. The STAT chest x-ray was not completed on [DATE]. The blood specimen was collected for the laboratory tests, which revealed the resident had a high critical sodium level of 161 millimoles per liter (mmol/L). This critical laboratory value was communicated to the facility nursing staff on [DATE]; however, the provider was unaware of the results until [DATE]. After review of the resident's clinical status and laboratory test results, concern was expressed by the providers for the resident's deterioration and agreed the resident required transfer to the hospital for further evaluation and management at a higher level of care. Resident #7 was transferred to the local hospital around 11:30 AM. Resident #7 arrived at the hospital and was noted to be hypotensive (low blood pressure) with agonal respirations. Cardiopulmonary resuscitation (CPR) was initiated when the resident was noted not to have a pulse. The resident remained pulseless despite multiple rounds of CPR and expired at 12:38 PM. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 483.25 Quality of Care, F684, Quality of Care at a scope and severity of J. The IJ began on [DATE] when the facility failed to complete an ordered STAT chest x-ray and promptly notify the provider of a critical and abnormal laboratory test values for Resident #7.The survey team notified the Administrator, Director of Nursing, and four clinical advisors of the IJ and provided the IJ template on [DATE] at 11:00 AM. A removal plan was requested. The facility's removal plan was accepted by the state survey agency on [DATE] at 8:34 PM. The IJ was removed on [DATE], after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F684 remained at a lower scope and severity of D, isolated/no actual harm with the potential for more than minimal harm.Findings included: A facility policy titled, NSG122 Change in Condition: Notification of, revised [DATE], specified: Policy A Center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: * An accident involving the patient which results in injury and has the potential for requiring physician intervention; * A significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); * A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or * A decision to transfer or discharge the patient from the Center. When making notification of above, the Center must ensure that all pertinent information is available and provided upon request to the physician. Purpose To provide appropriate and timely information about changes relevant to the patient's condition. A Face Sheet indicated the facility admitted Resident #7 on [DATE]. According to the Face Sheet, the resident has a medical history that included atherosclerotic heart disease, paroxysmal atrial fibrillation, encephalopathy, vascular dementia, traumatic subdural hemorrhage, hypertension, and cognitive communication deficit. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #7's Progress Notes, written by NP #6 and dated [DATE] at 11:17 AM, revealed the NP was requested to evaluate the resident for acute respiratory distress. The Progress Notes indicated the resident had difficulty (continued on next page)

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	215264	A. Building B. Wing	04/14/2026

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing with the use of their accessory muscles, had lung crackles, and an oxygen saturation of 93-96% on room air. Per the Progress Notes, the NP ordered a treatment plan to include a STAT chest x-ray, STAT laboratory tests including a comprehensive metabolic panel (CMP), magnesium level, and a complete blood count (CBC) with differential to rule out pneumonia and assess for other possible underlying conditions.Resident #7's Order Details, revealed a physician's order dated [DATE] at 11:12 AM, for a STAT chest x-ray. Resident #7's Order Details, revealed a physician's order dated [DATE] at 11:15 AM, for a STAT CMP, magnesium level, and a CBC with differential. Resident #7's medical record revealed no evidence to indicate the STAT chest x-ray ordered on [DATE] was completed. Resident #7's laboratory test result report revealed a blood specimen was collected from the resident on [DATE] at 5:11 PM for CMP, magnesium level, and CBC with differential. Per the result, the resident's sodium level registered high critical at 161 mmol/L; the resident's blood urea nitrogen (BUN) registered high at 55 milligrams per deciliter (mg/dL); the resident's magnesium level registered high at 2.9 mg/dL; and the resident's white blood cell (WBC) count registered high at 29.68 10 cubed microliter (uL). Resident #7's Progress Notes, written by NP #6 and dated [DATE] at 11:51 AM, revealed Patient was seen today for follow-up of ongoing acute respiratory distress for which stat laboratory tests, chest X-ray, and DuoNeb treatments were ordered yesterday [[DATE]] due to increased work of breathing and clinical decline. Results of the stat laboratory tests obtained today [[DATE]] were reviewed and showed significant abnormalities, including markedly elevated WBC of 29.68 BUN of 55 consistent with acute kidney injury, and severe hypernatremia with sodium of 161. These findings are concerning for worsening condition with dehydration, possible infection, and renal impairment. The patient was started on half-normal saline at 124 cc (cubic centimeters) per hours for a total of 2 liters for hydration and sodium correction. Patient assessed at bedside awake at time, lethargic and showing clinical decline. [His/Her] vital stable with blood pressure 127/75 heart rate 64 temperature 96.6 oxygen 97 on room air. The provider discussed the patient's condition and abnormal laboratory results with [Resident #7's Attending Physician], who was in house at the time of evaluation. After review of the clinical status and labs, he expressed concern for the patients deterioration and agreed that the patient requires transfer to the hospital for further evaluation and management at a higher level of care. Resident #7's Order Details revealed a physician's order dated [DATE] at 11:27 AM, that specified to transfer the resident to the nearest emergency room due to critical laboratory values and an elevated WBC count. Resident #7's Emergency Department Provider Note, dated [DATE], revealed Per EMS [emergency medical services], they were called to the patient's rehab facility due to decreased oxygen saturation. On arrival, patient was noted to be hypotensive with agonal respirations. EMS established IO [intraosseous] access and began giving fluids. They began bagging the patient and then patient lost pulses. CPR [cardiopulmonary resuscitation] was started at 11:55 AM. Patient received 4 doses of epinephrine. [Resident #7] was noted to be asystole on the monitor. Per the Emergency Department Provider Note, Patient remained pulseless and asystole with cardiac standstill on ultrasound despite multiple rounds of CPR and medications. Given this, decision was made to terminate resuscitation efforts. Time of death 12:38 PM. During an interview on [DATE] at 11:28 AM, the Director of Nursing (DON) stated the facility did not have a written policy that provided guidance to staff on STAT orders, but there was a mutual expectation that STAT orders should be completed within four hours. During a telephone interview on [DATE] at 1:01 PM, the x-ray vendor representative stated the vendor received an order for an x-ray for Resident #7 on [DATE] and when the technician arrived at the facility to complete the x-ray, they were not able to complete the order because Resident #7 had already been sent to the emergency room. The x-ray vendor representative stated the vendor did not receive an order for a STAT chest x-ray on [DATE]. During a follow-up telephone interview on [DATE] at 11:57 AM, the x-ray vendor representative stated the vendor had eight hours to complete an x-ray, if it were ordered STAT. During a telephone interview on [DATE] at 3:10 PM, the laboratory vendor representative stated the laboratory vendor received an order for Resident #7 on [DATE] at 11:20 AM, the laboratory collected (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the blood specimen at 3:30 PM, and the results were reported to the Evening Nursing Supervisor at 8:57 PM on [DATE]. During an interview on [DATE] at 1:00 PM, the Evening Nursing Supervisor stated she did recall receiving a telephone call about Resident #7's critical and abnormal laboratory values. The Evening Nursing Supervisor stated she did not think it was her who the laboratory called. During an interview on [DATE] at 10:32 AM, NP #6 stated she was not aware the chest x-ray was not completed and the facility should have contacted the provider when the critical laboratory test results came in. NP #6 stated had she been notified the evening of [DATE] when the resident's laboratory test results were received, she would have sent the resident to the hospital. During a follow-up interview on [DATE] at 11:06 AM, the DON stated the nurses were responsible for following up on STAT orders, notifying the provider if laboratory tests and/or x-rays were not completed, and reporting all critical laboratory values immediately. The DON stated when Resident #7's critical laboratory test results were received, the facility should have reported the results to the on-call provider. The DON confirmed she was unaware Resident #7's critical laboratory test results were not reported to the provider. During a telephone interview on [DATE] at 10:44 AM, the Medical Director (MD) stated the expectation was for providers to be notified immediately of any change in a resident's condition, all critical laboratory test results, or if an order could not be carried out. According to the MD, he felt the outcome for Resident #7 would have been the same regardless of when the resident was sent to the hospital. During an interview on [DATE] at 4:12 PM, the Administrator stated he expected provider notification whenever there was a change in a resident's condition, including when critical laboratory test results were received or when laboratory or x-ray orders could not be completed. The facility submitted a removal plan that was accepted by the state survey agency on [DATE] at 8:34 PM. The removal plan indicated the following: F684 - Quality of Care: Removal Plan This Plan of Removal is in response to the identification of Immediate Jeopardy communicated by the survey team on [DATE]. The Facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements.Corrective Action Identification of residents affected or likely to be affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. Resident #7 is no longer admitted to the facility; therefore, a corrective action cannot be completed. Current residents presenting with a change in condition, as per Policy NSG122 Change in Condition: Notification of were reviewed by the DON and clinical regional nurses to ensure the following: (1) notification of change in condition to medical provider (2) new orders documented (if applicable) by [DATE]. On [DATE] at 6:44 PM, only three current residents presented a change in condition. Actions to prevent occurrence/reoccurrence: The facility took the following actions to prevent an adverse outcome from occurring. The DON and/or designee educated licensed nurses including agency nurses working on [DATE] on notification to the medical provider regarding a change in condition (Policy NSG122 Change in Condition: Notification of). Licensed nurses including agency nurses not working and not on leave or vacation on [DATE] will be re-educated by [DATE]. The education will be added to the agency nurse's orientation packet and provided prior to the start of the first shift worked. The DON and/or designee will review the clinical assessment, eINTERACT Change in Condition Evaluation to verify notification to the medical provider daily x3, weekly x4, then monthly x2. The Administrator will review the results of the audits in a weekly ad hoc quality assurance performance improvement (QAPI) to ensure compliance has been achieved and sustained. All corrections were completed on [DATE]. The immediacy of the IJ was removed on [DATE]. The IJ was removed on [DATE] at 10:00 AM after the survey team verified the facility's implementation of the removal plan as follows: Step 1 - Staff education on STAT orders and change-in-condition protocolRemoval Plan Action: Licensed nurses, including agency staff, were to receive immediate education on:-STAT order completion and escalation (4-hour threshold)-Notification requirements for abnormal findingsSurvey Team Verification: The survey team reviewed sign-in sheets and confirmed training was provided on [DATE] and supplemented through phone in-services between [DATE] and [DATE] for staff not present. Education materials were added to the agency (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurse orientation packet.The survey team interviewed licensed nurses across all shifts between [DATE] and [DATE]. All staff accurately described:-STAT order protocol (completion within 4 hours, or call provider if delayed)-Notification thresholds for abnormal labs-Process for escalating orders that cannot be implemented Step 2 - Change-in-condition and STAT escalation auditsRemoval Plan Action: Daily audits were initiated to confirm provider notification and correct implementation of new orders for identified changes in condition. Planned frequency: daily x3, weekly x4, monthly x2. Survey Team Verification: The team reviewed completed audits for [DATE] and [DATE] documenting nine instances of a change in condition, all with timely notification and documented follow-up. Step 3 - QAPI MonitoringRemoval Plan Action: Weekly ad hoc QAPI meetings to confirm compliance trends and sustainability. Survey Team Verification: The team reviewed minutes from the [DATE] QAPI meeting, which included review of change of condition logs, and staff education compliance. The DON and Administrator demonstrated ongoing monitoring systems. The survey team validated through record review and interviews with nurses across all shifts plus the DON and the Market Clinical Lead, that the immediate jeopardy removal plan was fully implemented and systemic corrections were in place.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure there was an order to perform wound care when Resident #6 was identified to have an in-house acquired Stage 2 pressure ulcer. The facility further failed to ensure an order to perform wound care was transcribed and implemented for Resident #9's in-house acquired Stage 3 pressure ulcer; notify the Lead Registered Dietician of the resident's new pressure ulcer; and ensure there was not inconsistencies in how the resident's pressure ulcer was assessed and documented. These failures affected 2 (Resident #6 and Resident #9) of 3 sampled residents reviewed for pressure ulcer/injury.Findings included: A facility policy titled, NSG236 Skin Integrity and Wound Management, revised 09/15/2025, revealed PURPOSE To provide safe and effective care to promote optimal skin health, prevent injuries, and promote healing within the context of what matters most to all patients. The policy specified, 6.7 Notify interdisciplinary team members for a comprehensive approach to care including prevention and wound treatments, as indicated and 6.13 Implement special wound care treatments/techniques, as indicated and ordered. 1. A Face Sheet indicated the facility admitted Resident #6 on 02/02/2026. According to the Face Sheet, the resident had a medical history that included diagnoses of left femur fracture, fracture of the right lower leg, and orthopedic aftercare. Per the Face Sheet, Resident #6 discharged home on [DATE]. An admission Minimum Data Set (MDS), with an Assessment Reference Data (ARD) of 02/09/2026, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was at risk of developing pressure ulcers/injuries and had no unhealed pressure ulcers/injuries. Resident #6's Care Plan Report included a focus area initiated 02/11/2026, that indicated the resident was at risk for skin breakdown due to decreased mobility. Resident #6's Skin Issues note completed by the Skin Health Team Lead (SHTL) and dated 03/06/2026 at 9:45 AM, indicated the resident was found to have a Stage 2 pressure ulcer on their right posterior lower leg that measured 8.93 centimeters (cm) in length and 5.43 cm in width. Resident #6's Skin Issues note completed by the SHTL and dated 03/12/2026 at 2:57 PM, indicated the resident's Stage 2 pressure ulcer on their right posterior lower leg measured 10.51 cm in length and 7.17 cm in width. Resident #6's Order Recap Report, for the timeframe 02/01/2026 - 03/31/2026, revealed an order dated 03/18/2026 to start on 03/19/2026, that directed staff to clean the resident's right posterior lower leg with wound cleanser, pat try, apply xeroform gauze, and cover with a foam dressing every other day and as needed. Resident #6's Treatment Administration Record [TAR] for the time frame 03/01/2026 - 03/31/2026, revealed the transcription of an order with a start date of 03/19/2026, to cleanse the resident right posterior lower leg with wound cleanser, pat dry, apply xeroform gauze, and cover with a dressing every other day. Per the TAR, Licensed Practical Nurse #31 initialed the TAR to indicate she provided wound care as ordered to the resident on 03/19/2026. During an interview on 04/09/2026 at 9:01 AM, the SHTL stated Resident #6 developed an in-house acquired pressure ulcer to their posterior right lower leg related to a device the resident had on their leg. The SHTL stated wound care to the resident's posterior leg was performed daily. The SHTL reviewed Resident #6's medical record and confirmed wound care orders were not implemented for the resident's Stage 2 pressure ulcer until 03/18/2026, the day before the resident discharged home. According to the SHTL, she could not say why there were no wound care orders prior to 03/18/2026 even though the resident's pressure ulcer was identified on 03/06/2026. During an interview on 04/13/2026 at 8:33 AM, the Director of Nursing stated she was not sure about Resident #6's Stage 2 pressure ulcer development. During an interview on 04/13/2026 at 4:12 PM, the Administrator stated residents' wounds must be monitored and documented appropriately. 2. A Face Sheet indicated the facility admitted Resident #9 on 08/05/2025. According to the Face Sheet, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-dominant side. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/2026, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was not at risk of developing pressure ulcers/injuries and had no unhealed pressures ulcers/injuries. Resident #9's Care Plan Report included a focus area initiated 08/07/2025, that indicated the resident was at risk for skin breakdown related to incontinence, limited mobility, and a pressure ulcer on their right gluteus/sacral area, left heel, and left lateral ankle. Interventions directed the staff to complete a weekly wound assessment to include measurements and description of the wound status (initiated 08/07/2025). Resident #9's eINTERACT SBAR [Situation Background Assessment Recommendation] Summary for Providers note completed by the Evening Nursing Supervisor and dated 01/06/2026 at 4:53 PM, revealed During wound round and skin assessment, resident was found with MASD [moisture-associated skin damage] on the left gluteal area. The wound Doctor ordered to cleanse the wound with generic wound cleanser; pat dry and happy [apply] med honey + calcium alginate and cover with dry dressing. Resident #9's Order Recap Report for the timeframe 08/01/2025 - 04/30/2026, revealed no evidence of the transcription of an order dated 01/06/2026, to cleanse the resident's wound with generic wound cleanser, pat dry, apply med honey + calcium alginate, and cover with dry dressing. Resident #9's Treatment Administration Record [TAR] for the timeframe 01/01/2026 - 01/31/2026, revealed no evidence of the transcription of an order dated 01/06/2026, to cleanse the resident's wound with generic wound cleanser, pat dry, apply med honey + calcium alginate, and cover with dry dressing. Resident #9's Skin Issues note completed by the Director of Nursing (DON) and dated 01/28/2026, indicated the resident had in-house acquired MASD on their left gluteus that measured 1.07 centimeters (cm) in length and 1.53 cm in width, with no undermining or tunneling and 100% granulation tissue. Resident #9's Progress Notes electronically signed by the Wound Physician and dated 01/28/2026, indicated the resident had a Stage 3 pressure ulcer on their sacrum that measured 1 cm by (x) 0.5 cm x 0.1 cm with no exudate and 50% granulation tissue and 50% epithelization. Resident #9's Skin Issues note completed by the Skin Health Team Lead (SHTL) and dated 03/09/2026, indicated the resident had in-house unstageable pressure ulcer due to slough and eschar on their left gluteus that measured 5.31 cm in length and 4.53 cm in width and wound healing had stalled. Resident #9's Progress Notes electronically signed by the Wound Physician and dated 03/10/2026, indicated the resident had a Stage 3 pressure ulcer on their sacrum that measured 2 cm x 1 cm x 0 cm with no exudate and 50% granulation tissue and 50% epithelization. Resident #9's Skin Issues note completed by the SHTL and dated 03/16/2026, indicated the resident had in-house unstageable pressure ulcer due to slough and eschar on their sacrum that measured 8.34 cm in length and 5.79 cm in width and the wound characteristics had improved. Resident #9's Progress Notes electronically signed by the Wound Physician and dated 03/17/2026, indicated the resident had a Stage 3 pressure ulcer on their sacrum that measured 4 cm x 3 cm x 0 cm with no exudate and 50% granulation tissue and 50% epithelization and the wound progress was listed as Deteriorating. Resident #9's Progress Notes electronically signed by the Wound Physician and dated 03/31/2026, indicated the resident had a Stage 3 pressure ulcer on their sacrum that measured 3.5 cm x 1.5 cm x 0.1 cm with moderate exudate and 50% granulation tissue and 50% epithelization and the wound progress was listed as Improving. Resident #9's Skin Issues note completed by the SHTL and dated 04/01/2026, indicated the resident had in-house unstageable pressure ulcer due to slough and eschar on their sacrum/left glute that measured 7.46 cm in length, 6.41 cm in width, and 0.3 cm in depth, with 10% epithelial tissue, 70% granulation tissue, and 20% slough, with light serosanguineous exudate (bloody drainage) and the wound progress was listed as improved. Resident #9's Order Recap Report for the timeframe 08/01/2025 - 04/30/2026, revealed an order dated 01/25/2026, to cleanse the resident's left gluteal wound with wound cleanser, pat dry, apply hydrogel, and cover with a gauze and foam dressing daily. Per the Order Recap Report, this order ended on 02/09/2026. Resident #9's Order Recap Report for the timeframe 08/01/2025 - 04/30/2026, revealed an order dated 03/26/2026, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to cleanse the resident's sacral wound with wound cleanser, pat dry, apply plurogel to the wound bed, then calcium alginate, and cover with a foam dressing every day and as needed. Per the Order Recap Report, this order was discontinued on 04/03/2026. Resident #9's Order Recap Report for the timeframe 08/01/2025 - 04/30/2026, revealed an order dated 04/03/2026, to cleanse the resident's sacral wound with wound cleanser, pat dry, apply calcium alginate, and cover with a foam dressing one time only for one day and every day shift. During an interview on 04/09/2026 at 3:17 PM, Resident #9's Emergency Contact stated they were unaware the resident had a wound on their sacrum since 01/2026. The Emergency Contact stated they were called last week (03/29/2026 - 04/04/2026) and told of the resident's wound, so they were under the impression the wound had just developed. During an interview on 04/09/2026 at 3:21 PM, the Lead Registered Dietician (RD) stated she was not familiar with Resident #9. The Lead RD reviewed Resident #9's medical record and stated that it did not look like the facility implemented any new orders when the resident's wounds developed. The Lead RD stated the resident's diet with their protein needs was appropriate, but she would have expected the facility to notify her the resident developed wounds. The Lead RD stated now that she knew the resident had wounds, she would reassess the resident's nutritional needs. During an interview on 04/13/2026 at 8:33 AM, the Director of Nursing (DON) stated the facility had skin meetings where they discussed the status of residents' wound; however, they did not do a deep dive into the residents' wounds to determine if the orders were appropriate or implemented. The DON stated she was not sure why the facility staff did not document Resident #9's pressure ulcer as a Stage 3 as the Wound Physician did. The DON stated she was not able to state why orders were missed to treat the resident's pressure ulcer. The DON stated she expected wound care orders to be implemented and if not, discussed with the provider. During an interview on 04/13/2026 at 4:12 PM, the Administrator stated residents' wounds must be monitored and documented appropriately.