

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Larkin Chase Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interview, and record review, it was determined that the facility failed to ensure that staff interacted with residents in a courteous, respectful and responsive manner. This was evident for 1 (Resident #71) of 1 Resident monitored for a dignified existence and 1 (Resident #2) of 2 residents investigated for abuse. The findings include: 1) During an observation on 7/06/2026 at 12:03 PM Resident #71 was observed hunched over while being pushed in a wheelchair at a moderate pace through the hallway near the North Wing Nursing Station by Occupation Therapy Assistant (OTA) #30. During continued observation it was noted that the legs of Resident #71 were observed to be bent at the knees with the legs being dragged on the floor below the seat of the wheelchair, his/her ankles were flexed backwards with the tops of his/her toes dragging on the floor. Additional observation revealed there were no footrest attached to the wheelchair. OTA #30 continued with transporting Resident #71 to the North Wing Dining room. During an interview with OTA #30 on 7/06/2026 at 12:04 PM she reported she was returning Resident #71 from therapy. She advised she needed a wheelchair so she grabbed the first one she could find for Resident #71. She reported the wheelchair didn't have any leg rest attached when she chose it for Resident #71 and advised there were no other chairs available. During an interview with Director of Rehab #31 on 7/06/2026 at 12:15 PM she reported the expectation for using leg rest with wheelchairs was that if the resident can self-propel themselves, leg rest are not required and if the resident is unable to self-propel themselves, they should have leg rest on their wheelchair. During an interview with Occupational Therapist #32 on 7/06/2026 at 12:26 PM she reported the expectations are for Residents that can't control their legs to have leg rest on their wheelchair because we don't want them dragging on the floor. She advised she had provided therapy to Resident #71 previously and advised the Resident was totally dependent on staff, the resident would not be able to lift his/her legs and did not have the ability follow commands. She confirmed that Resident #71 cannot self-propel his/herself and that she/he should have had the leg rests on the wheelchair for transport when leaving therapy. She reported we try to make sure everyone has leg rest. She confirmed that leg rest are not always available as some leg rest go missing and we have to find new ones. (continued on next page)		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 7/1/26 at 2:50 PM, a facility reported incident (FRI) #2974437 was reviewed. The report indicated that Licensed Practical Nurse (LPN) #25 argued with and stated That's what's wrong with people in America, they want things done immediately, when a family member reported an hour-long delay in pain medication administration for Resident #2. Further review of the FRI revealed a witness statement by Registered Nurse (RN) #33 that confirmed what LPN #25 said. On 07/02/2026 at 11:08 AM, in a record review of employee file for LPN #25, it is noted that he/she completed online continuing education for customer service and effective communication as well as culturally competent care on 4/9/26. On 07/02/2026 at 1:08 PM, in an interview with the Administrator and after review of residents file, he confirms that there is evidence that LPN #25 made these statements in front of residents.		

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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 record review and interview, the facility failed to thoroughly investigate an allegation of verbal abuse for 1 (Resident #2) of 2 residents reviewed for abuse investigations. The findings include: On 7/1/26 at 2:50 PM, a review of the facility reported incident (FRI) #2974437 was initiated. The report indicated that Licensed Practical Nurse (LPN) #25 argued with and stated That's what's wrong with people in America, they want things done immediately, when a family member reported an hour-long delay in pain medication administration for Resident #2. Further review of the FRI revealed a witness statement by Registered Nurse (RN) #33 that confirmed what LPN #25 said. Additional review of the FRI documents revealed an interview between the Administrator and LPN #25 where it is documented that LPN #25 had said the statement was not intended in the way that it was interpreted. In the report investigation, it is stated that other residents who may have had contact with LPN #25 denied any such experiences. However in the witness statements, one resident had remarked that LPN #25 was snappy, a statement which was not included in the investigation report. The facility also failed to include in the documentation that RN #33 witnessed the alleged event and provided his/her account. The conclusion of the investigation stated, The allegation was unable to be verified because interviews with other residents who may have had contact stated they had no similar experiences and the perpetrator stated his words were misinterpreted. The report cites Not applicable (N/A) for any corrective action for the employee. 07/02/2026 at 1:08 PM, in an interview with the Administrator regarding the FRI investigation, this surveyor questioned the missing information about witness statements in the report. He admitted that was an error, and he interviewed staff but failed to include the information. When questioned why the report from the resident interviews did not include the one resident statement that LPN #25 could be snappy, his response was that it was discussed and found to be differences in culture, but could not say why he did not include that statement in the investigative report. When asked about RN #33's witness statement not being included in the investigative report, he did not have an answer. When asked to provide documentation of any corrective action taken as a result of this incident, he produced documents for facility - wide training on customer service, but no specific corrective action for LPN #25. When asked if this witness statement had proven the complainant's allegation, he agreed.		