STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Largo Nursing and Rehabiliation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Largo Road Glenarden, MD 20774	

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 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 observation, interview, record review, and facility policy review, the facility failed to ensure fall interventions were implemented as care planned for 2 (Resident #4 and Resident #6) of 3 sampled residents reviewed for falls.The findings include:A facility policy titled, Care Planning, effective 11/01/2019, indicated, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.1. An admission Record revealed the facility admitted Resident #6 on 11/17/2025. According to the admission Record, the resident had a medical history that included diagnoses of other cerebral infarction and hemiplegia and hemiparesis following cerebral infarction. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. Resident #6's Care Plan Report included a focus area initiated 12/28/2025, that indicated the resident was at risk for falls due to a recent hospitalization. Interventions directed the staff to place falls mats to both sides of the resident's bed (initiated 01/07/2026) and to place the resident's bed in the lowest position while the resident was in bed (initiated 11/18/2025). During an observation of Resident #6's room on 02/11/2026 at 4:23 PM, the resident was in bed and there were no fall mats on either side of the resident's bed. During a concurrent observation and interview on 02/12/2026 at 3:50 PM, Resident #6 was observed in bed. Geriatric Nursing Assistant #7 observed Resident #6's room and stated fall mats were not in place next to the resident's bed. During an interview on 02/13/2026 at 11:30 AM, the Assistant Director of Nursing (ADON) stated fall mats were added to Resident #6's care plan as an intervention after the resident experienced a fall. During a concurrent observation and interview on 02/13/2026 at 11:52 AM, Resident #6 was observed in bed. The ADON observed Resident #6's room and stated the resident's bed was not in the lowest position and the fall mats were not in place next to the resident's bed and they should have been according to the resident's care plan. 2. An admission Record revealed the facility admitted Resident #4 on 12/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction, muscle weakness, cerebral infarction, and lack of coordination. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/30/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #4's Care Plan Report included a focus area initiated 12/27/2025, that indicated the resident was at risk for falls related to weakness and hemiplegia recent hospitalization. Interventions directed staff to place fall mats to the sides of the resident's bed (initiated 01/05/2026). During an observation of Resident #4's room on 02/10/2026 at 10:58 AM and 02/11/2026 at 10:49 AM, the resident was in bed and there were no fall mats present. During (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a concurrent observation and interview on 02/11/2026 at 11:14 AM, Geriatric Nursing Assistant #2 observed Resident #4's room and stated there should be fall mats placed by the resident's bed. During an interview on 02/13/2026 at 11:45 AM, the Assistant Director of Nursing (ADON) stated fall mats on the side of Resident #4's bed was the intervention placed on the resident's care plan after the resident had a fall. During a concurrent observation and interview on 02/13/2026 at 3:07 PM, the ADON observed Resident #4's room and stated fall mats were not present and there should be according to the resident's care plan. During an interview on 02/13/2026 at 2:54 PM, the Director of Nursing stated she expected fall interventions to be implemented. During an interview on 02/13/2026 at 3:26 PM, the Administrator stated she expected fall interventions to be implemented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff provided the appropriate level of assistance for bed mobility to ensure a resident did not fall from their bed for 1 (Resident #6) of 3 sampled residents reviewed for falls. The facility further failed to ensure fall interventions were implemented for 2 (Resident #4 and Resident #6) of 3 sampled residents reviewed for falls.The findings include:A facility policy titled, Falls Management Program, effective 01/29/2024, indicated, The center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systematic approach to a falls management program that facilitates an interdisciplinary approach with evidence-based interventions to develop individual care strategies. 1. An admission Record revealed the facility admitted Resident #6 on 11/17/2025. According to the admission Record, the resident had a medical history that included diagnoses of other cerebral infarction and hemiplegia and hemiparesis following cerebral infarction. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene and to roll left and right in bed. Resident #6's Care Plan Report included a focus area initiated 11/18/2025, that indicated the resident required assistance with activities of daily living. Interventions directed staff to provide two-person assistance with bed mobility (initiated 11/18/2025). The Care Plan Report also included a focus area initiated 12/28/2025, that indicated the resident was at risk for falls due to a recent hospitalization. Interventions directed the staff to place falls mats to both sides of the resident's bed (initiated 01/07/2026) and to place the resident's bed in the lowest position while the resident was in bed (initiated 11/18/2025). Resident #6's progress note created by Registered Nurse (RN) #12 and dated 12/28/2025, indicated RN #12 was notified by the resident's assigned nurse that Resident #6 fell during activity of daily living care with no injuries noted. During an interview on 02/11/2025 at 4:04 PM, Licensed Practical Nurse (LPN) #5 stated she worked the day that Resident #6 fell. LPN #5 stated Geriatric Nursing Assistant (GNA) #9 told her that she was providing care to resident, when she pulled the resident toward her to turn the resident in bed, and the resident rolled off the bed. Per LPN #5, Resident #6 was too heavy for GNA #9 to hold on to, so GNA #9 lowered the resident to the floor. During an interview on 02/12/2026 at 2:36 PM, GNA #9 stated she was providing incontinence care to Resident #6 when the resident fell. GNA #9 stated when she released contact with the resident to retrieve an incontinence brief, the resident began to roll forward. GNA #9 stated she ran to the resident's right side of the bed and caught the resident mid fall and eased the resident to the floor. GNA #9 stated she thought the resident was a one-person assist. During an interview on 02/13/2026 at 11:30 AM, the Assistant Director of Nursing (ADON) stated Resident #6 required two-person assistance for bed mobility. During an interview on 02/13/2026 at 1:02 PM, LPN #10 stated Resident #6 required two-person assistance for bed mobility and there should have been two people present to provide care when the resident fell during care. During an interview on 02/13/2026 at 2:54 PM, the Director of Nursing stated she expected that when a resident required two-person assistance for bed mobility, two people should be present to provide the care. During an interview on 02/13/2026 at 3:26 PM, the Administrator stated she expected the staff to provide the right level of assistance to residents when care was being provided. During an observation of Resident #6's room on 02/11/2026 at 4:23 PM, the resident was in bed and there were no fall mats on either side of the resident's bed. During a concurrent observation and interview on 02/12/2026 at 3:50 PM, Resident #6 was observed in bed. Geriatric (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Assistant #7 observed Resident #6's room and stated fall mats were not in place next to the resident's bed. During an interview on 02/13/2026 at 11:30 AM, the ADON stated fall mats were added to Resident #6's care plan as an intervention after the resident experienced a fall. During a concurrent observation and interview on 02/13/2026 at 11:52 AM, Resident #6 was observed in bed. The ADON observed Resident #6's room and stated the resident's bed was not in the lowest position and the fall mats were not in place next to the resident's bed and they should have been according to the resident's care plan. 2. An admission Record revealed the facility admitted Resident #4 on 12/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction, muscle weakness, cerebral infarction, and lack of coordination. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/30/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #4's Care Plan Report included a focus area initiated 12/27/2025, that indicated the resident was at risk for falls related to weakness and hemiplegia recent hospitalization. Interventions directed staff to place fall mats to the sides of the resident's bed (initiated 01/05/2026). During an observation of Resident #4's room on 02/10/2026 at 10:58 AM and 02/11/2026 at 10:49 AM, the resident was in bed and there were no fall mats present. During a concurrent observation and interview on 02/11/2026 at 11:14 AM, Geriatric Nursing Assistant #2 observed Resident #4's room and stated there should be fall mats placed by the resident's bed. During an interview on 02/13/2026 at 11:45 AM, the Assistant Director of Nursing (ADON) stated fall mats on the side of Resident #4's bed was the intervention placed on the resident's care plan after the resident had a fall. During a concurrent observation and interview on 02/13/2026 at 3:07 PM, the ADON observed Resident #4's room and stated fall mats were not present and there should be according to the resident's care plan. During an interview on 02/13/2026 at 2:54 PM, the Director of Nursing stated she expected fall interventions to be implemented. During an interview on 02/13/2026 at 3:26 PM, the Administrator stated she expected fall interventions to be implemented.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #7) of 20 sampled residents was free from a significant medication error when staff administered an anticonvulsant medication, Dilantin, to a resident when there was an order to hold the medication.The findings include: A facility policy titled General Guidelines for Medication Administration, effective 09/2018, indicated Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. The policy specified, 2. Medications are administered in accordance with written orders of the prescriber. An admission Record indicated the facility admitted Resident #7 on 09/10/2021. According to the admission Record, the resident had a medical history that included a diagnosis of seizures. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2025, indicated Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident received an anticonvulsant medication during the assessment period. Resident #7's Care Plan Report included a focus area initiated 02/02/2023, that indicated the resident was at risk for complications secondary to seizures. Interventions directed the staff to administer medications as ordered (initiated 02/02/2023). Resident #7's Order Summary Report for active orders as of 12/15/2025, revealed an order dated 12/03/2025, for Dilantin Infatabs oral tablet chewable 50 milligrams, give three tablets by mouth two times a day for seizures. Resident #7's Health Status Note electronically signed by Licensed Practical Nurse (LPN) #5 and dated 12/16/2025 at 6:17 PM, indicated the resident remained alert and verbally responsive. Per the Health Status Note, the resident's Dilantin was on hold. Resident #7's Laboratory Note electronically signed by LPN #5 and dated 12/16/2025 at 8:00 PM, indicated the resident's laboratory tests results were received and the resident's Dilantin level was greater than 40 micrograms per milliliter (mcg/mL). Per the Health Status Note, the physician was notified and provided an order for the staff to hold the resident's Dilantin and repeat the Dilantin level on 12/18/2025. Resident #7's Medication Admin [Administration] Audit Report for medications scheduled during the timeframe 12/01/2025 - 12/31/2025 indicated LPN #5 administered Dilantin to the resident on 12/16/2025 at 11:44 PM. During a telephone interview on 02/12/2026 at 3:04 PM, Physician #8 stated he was concerned that Resident #7 received more Dilantin after he ordered the medication to be held, but Resident #7 had no lasting effect from the extra dose of Dilantin. During an interview on 02/12/2026 at 3:41 PM, LPN #5 stated she was assigned to care for Resident #7 on 12/16/2025 when the laboratory notified the facility of the resident's elevated Dilantin level. LPN #5 reviewed the resident's electronic medical record and confirmed she administered Dilantin to the resident on 12/16/2025. During an interview on 02/13/2026 at 10:34 AM, the Assistant Director of Nursing (ADON) stated Resident #7 should not have received the scheduled dose of Dilantin after the elevated laboratory test result was received. The ADON reviewed the resident's electronic medical record and confirmed LPN #5 administered a dose of Dilantin to the resident on 12/16/2025 when the medication should have been held. During an interview on 02/13/2026 at 1:02 PM, the Director of Nursing (DON) stated she was aware of Resident #7's elevated Dilantin level. The DON reviewed the resident's electronic medical record and stated the nurse signed the document that specified she administered the medication to the resident. During an interview on 02/13/2026 at 2:28 PM, the Administrator stated she expected the nurse to follow the physician's orders.

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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 observation, interview, record review, and facility policy review, the facility failed to ensure staff wore personal protective equipment (PPE) when they entered the room of a resident on contact precautions and when they provided care to a resident on enhanced barrier precautions (EBP) for 2 (Resident #10 and Resident #12) of 2 sampled residents reviewed for infection control.Findings included: A facility policy titled, Transmission Based Precautions-General Practice, effective 12/01/2021, indicated The Center initiates transmission-based precautions (TBPs) to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease. The TBPs will be based on the type of pathogens, knowledge of the natural history of certain diseases and studies of epidemiology. 1. An admission Record indicated the facility admitted Resident #10 on 09/18/2017. The admission Record revealed the resident had a medical history that included diagnoses of a local infection of the skin and subcutaneous tissue and extended spectrum beta lactamase (ESBL) resistance. Resident #10's Order Summary Report with active orders as of 02/09/2026, revealed an order dated 01/28/2026, for contact precautions for an ESBL wound infection every shift. Resident #10's Care Plan Report included a focus area initiated 01/28/2026, that indicated the resident required contact precautions related to an ESBL wound infection. Interventions directed staff to use appropriate PPE per policy (initiated 01/28/2026) and to maintain isolation precautions per order (initiated 01/28/2026). During a concurrent observation and interview on 02/11/2026 at 8:48 AM, there was a sign posted on the resident's door that specified contact isolation. Licensed Practical Nurse (LPN) #1 entered Resident #10's room, without wearing a gown or gloves, and stood next to the resident's bed. LPN #1 stated she was required to wear a gown and gloves when she entered Resident #10's room if she was providing care to the resident. LPN #1 stated she did not put on a gown or gloves because she was only in Resident #10's room to ask a question and did not provide care. LPN #1 then reviewed the contact isolation information posted on the resident's door and stated she should have put on gown and gloves before she entered the resident's room. The Assistant Director of Nursing (ADON), who functioned as the Infection Preventionist, was interviewed on 02/12/2026 at 12:22 PM and stated if staff entered a room of a resident on contact isolation, for any reason, even to ask a question, the staff must put on both a gown and gloves. The Director of Nursing (DON) was interviewed on 02/13/2026 at 1:02 PM and stated if a resident was on contact isolation a gown and gloves were to be worn whenever the staff entered the resident's room. The DON stated the PPE was needed to keep the staff from transferring the organisms. The Administrator was interviewed on 02/13/2026 at 2:28 PM and stated if a resident required EBP or contact isolation the staff were expected to wear PPE as listed on the signage. 2. An admission Record revealed the facility had admitted Resident #12 on 01/26/2026. According to the admission Record, the resident had a medical history that included a diagnosis of urinary retention. Resident #12's Order Summary Report with active orders as of 02/09/2026, revealed an order dated 01/26/2026, for EBP for urinary catheter and surgical wound every shift. Resident #12's Care Plan Report indicated a focus area initiated 01/27/2026, that indicated the resident had an indwelling urinary catheter secondary to urinary retention. Interventions informed staff the resident required EBP (initiated 01/27/2026). During an observation on 02/10/2026 at 11:33 AM, Geriatric Nursing Assistant (GNA) #2 and Licensed Practical Nurse (LPN) #3 used a mechanical lift to transfer Resident #12 from their bed to their wheelchair. GNA #2 and LPN #3 wore gloves, but neither staff member had on a gown when they used the mechanical lift to transfer the resident. LPN #3 was interviewed on 02/10/2026 at 1:20 PM and stated EBP should be utilized to include the wearing of PPE when caring for residents that had urinary catheters. LPN #3 stated when the transfer started and she saw the resident's urinary catheter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she should have stopped the transfer and put on a gown. GNA #2 was interviewed on 02/10/2026 at 1:45 PM and stated EBP was used for residents that had wounds, infections, feeding tubes, or catheters. GNA #2 stated if a resident was on EBP, a gown and gloves were to be worn when care was provided. The Assistant Director of Nursing (ADON), who functioned as the Infection Preventionist, was interviewed on 02/12/2026 at 12:22 PM and stated EBP was required when a resident had wounds, intravenous access, indwelling urinary catheters, or feeding tubes. The ADON stated if staff provided care to the resident, then the staff must use both a gown and gloves and would be needed when transferring a resident with a mechanical lift. The Director of Nursing (DON) was interviewed on 02/13/2026 at 1:02 PM and stated that if a resident was on EBP the staff were expected to wear PPE when care was provided including transferring a resident. The DON stated this was needed to keep organisms from being transferred. The Administrator was interviewed on 02/13/2026 at 2:28 PM and stated if a resident required EBP or contact isolation the staff were expected to wear PPE as listed on the signage.