STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215331	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on investigation into a complaint, clinical record review and staff interviews, it was determined that the facility failed to implement provider-recommended interventions to prevent pressure ulcers for residents. This was evident for 1 (Resident #8) of 3 residents reviewed for pressure ulcers during the complaint survey. The findings include:On 04/13/2026 at 9:15 AM, a review of complaint #2749307 revealed allegations that Resident #8 developed a pressure ulcer to the sacrum and wounds to both feet while residing in the facility.On 04/13/2026 at 10:02 AM, clinical record review revealed a Skin and Wound Progress Note dated 01/22/2026 that documented the resident had no wounds and was at risk for skin breakdown. The Wound Nurse Practitioner (NP) provider recommended preventative interventions, including floating heels while in bed.Review of Resident # 8's physician orders did not reveal orders to implement heel floating.Review of Resident # 8's care plan revealed the resident was identified as at risk for pressure ulcers; however, the care plan did not include interventions to float heels while in bed.Review of Resident # 8's Progress notes revealed a Skin and Wound Progress Note dated 02/20/2026 that documented the resident had developed multiple wounds, including pressure injuries to the heels/feet and a Stage 2 pressure ulcer to the sacrum.Continued review of Resident # 8's January and February 2026 Treatment Administration Records (TAR) revealed weekly skin assessments were documented as completed on 01/19/2026, 01/26/2026, 02/02/2026, 02/09/2026, and 02/16/2026. However, review of Resident #8's skin observation tool documentation did not reveal evidence to show that skin assessments were completed on those dates. Further review revealed one skin observation tool dated 02/20/2026 was completed since admission on [DATE].On 04/14/2026 at 11:24 AM, in an interview, the Assistant Director of Nursing (ADON) stated that the wound care provider assesses residents and communicates recommendations to the assigned nurse and unit manager, who are responsible for entering orders into the the electronic medical record, Point Click Care (PCC) and updating the resident's care plan. The ADON also stated that weekly skin assessments are completed for all residents and documented in PCC using the skin observation tool.On 04/14/2026 at 12:07 PM, subsequent clinical record review revealed documentation of a skin observation tool completed on 02/20/2026; however, there was no documentation to show weekly skin assessments were consistently completed from admission.In an interview on 04/14/2026 at 3:15 PM, Licensed Practical Nurse (LPN) #6 stated that residents receive weekly skin assessments which are documented in PCC using the skin observation tool. LPN #6 reviewed Resident #8's record together with the surveyor and confirmed that no additional weekly skin assessments were documented aside from the 02/20/2026 entry. LPN #6 further stated that when the wound care provider completes wound rounds, recommendations are documented in Progress Notes in PCC and communicated to the unit manager; however, she was not sure who is responsible for entering new orders based on those recommendations.In an interview on 04/14/2026 at 1:17 PM, the surveyor requested documentation related to Resident #8's weekly skin assessments.In a follow-up interview on 04/14/2026 at 3:58 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that TAR documentation indicated Resident #8 was checked weekly for skin assessments on 01/19/2026, 01/26/2026, 02/02/2026, 02/09/2026, and 02/16/2026; however, there was no (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in Resident #8's clinical record to support that the skin observation tool was completed on those dates. The DON and ADON also confirmed that the 01/22/2026 provider recommendation for Resident #8 to float heels while in bed was not implemented through physician orders or the care plan.At the time of exit conference, no additional documentation was provided to show that provider-recommended interventions for pressure ulcer prevention were implemented for Resident #8.