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	06/23/2026

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 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 review of a facility reported incident, record review, and staff interviews, it was determined that the facility failed to ensure an allegation of abuse was reported to the Office of Health Care Quality (OHCQ) timely as required. This was evident for 1 (Resident #1) of 4 residents reviewed during the complaint survey.The findings include:On 06/23/2026, review of the facility reported incident #3015153 revealed Resident #1 alleged Resident #4 entered the room and kicked the Resident's right leg on 04/19/2026. Further review of the facility investigation revealed the initial report to OHCQ was not submitted until 05/14/2026.Review of Resident #1's clinical record revealed a health status note written by LPN #4, dated 04/20/2026, documenting Resident #1's allegation, notification of the responsible party (RP), and stating, DON (Director of Nursing) was made aware.Review of the facility policy titled Responding to Abuse/Neglect/Misappropriation/Crime, effective 01/29/2024, revealed that staff observing or suspecting abuse are required to immediately report allegations to their immediate supervisor. The policy further revealed that the Administrator and/or Director of Nursing will promptly initiate the investigation and follow reporting guidelines.On 06/23/2026 at 4:20 p.m., during an interview, LPN #4 stated she responded to Resident #1's allegation on 4/19/2026 and reported the allegation to the DON.On 06/23/2026 at 5:17 p.m., during an interview, the DON revealed she was not aware of the allegation until 05/14/2026.On 06/23/2026 at 6:27 p.m., during an interview, the Administrator revealed that the allegation was not reported to OHCQ until 05/14/2026 because facility leadership was not aware of the incident before that date.At the time of the exit conference, the facility did not provide any additional information indicating that the allegation was reported timely to OHCQ as required.

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