STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215025	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Wheaton	4011 Randolph Road Wheaton, MD 20902

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50502 Based on review of facility investigation, record review, and interview, it was determined that the facility failed to ensure that a resident remained free of abuse. This was evident for 1 (Resident #105) of 31 abuse investigations reviewed during the survey. The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be past noncompliance with a compliance date of 3/11/24. The findings include: On 4/2/25 at 9:00 AM, a review of the Facility- Reported incident MD00203253 revealed that on 3/5/2024 at 12:30 PM, Geriatric Nurse Assistant (GNA #8) reported to the Nursing Home Administrator (NHA) and alleged Licensed Practical Nurse (LPN #6) of grabbing Resident #105's arm and hitting him/her on the face. On 4/3/24 at 7:45 AM, a review of Resident #105's medical records revealed a BIMS (Brief Interview for Mental Status: an assessment used in nursing homes and other long-term care facilities to monitor cognition) score of 0 out of 15 on 12/27/2023, which meant severe impairment. A care plan that was initiated on 3/27/2023 indicated, has potential to be verbally and physically aggressive related to Dementia. Dementia is a general term for the gradual decline in memory, thinking and other cognitive functions that can significantly impact daily life. On 4/3/24 at 8:23 AM, a review of the facility's investigation revealed that the alleged incident happened on 2/29/24 around 1:30 PM. However, the allegation was reported to the NHA on 3/5/2024 at 12:30 PM. The following interviews from the involved staff were conducted: On 3/5/2024 at 12:20 PM, GNA #8 reported to the NHA that on 2/29/24 he/she responded to assist GNA #7 who was giving care to Resident #105. The resident started yelling and became agitated. LPN #6 came to the room to assist, however, the resident hit LPN #6. GNA #8 stated that he/she and GNA # 7 witnessed LPN #6 grab and pinch the left hand and slapped Resident #105 on the forehead. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/24 at 12:31 PM, GNA #7 stated that on 2/29/24, while giving care to Resident #105, the resident started yelling and shouting, GNA #8 and LPN #6 came to assist. However, the resident hit the LPN #6 on the chest and then he/she grabbed Resident #105's hand and hit him/her in the face. On 3/6/24, LPN #6 stated that he/she did not abuse Resident #105 and only raised his/her hands and then grabbed the resident's hands and told him/her to stop the aggressive behavior. On 4/3/2025 at 11:05 AM, the surveyor reviewed and verified the corrective measures the facility implemented in response to the 2/29/2024 incident: 1. The alleged employee and witnesses were immediately suspended pending investigation a. LPN #6, who was the alleged perpetrator was placed on administrative leave pending investigation. He/she was terminated on 3/10/24. b. GNA #8 was disciplined for failing to immediately stop and report the alleged abuse per facility policy and education. He/she was suspended from 3/5 to 3/9/24 and received education handling aggressive behaviors with NHA on 3/10/2024. c. GNA #7 was disciplined for failing to immediately stop and report the alleged abuse per facility policy and education. He/she stated, I was scared to report and didn't know it. He/she was suspended from 3/5 to 3/9/2024 and received education handling aggressive behaviors with NHA on 3/9/24. 2. Interviews were obtained from the involved staff. 3. 17 other Staff members were also interviewed, and no issues were reported. 4. The Resident Representative was notified on 3/5/24 at 12:30 PM. 5. The Local Law Enforcement was notified on 3/5/24 at 12:40 PM. 6. The Ombudsman was notified on 3/5/24 at 1:30 PM. 7. Skin assessment was conducted. 8. Other Residents on the unit were unable to be interviewed, thus, head to toe skin assessments were completed for each resident with no negative findings. 9. The Social Worker visited Resident #105 on-3/5/24. 10. The Psychiatrist visited the Resident on 3/19/24. 11. Abuse education was conducted on 3/8/24, which was attended by 10 staff members and on 3/9/24 which was attended by 9 staff members. 12. The incident was reported to the Maryland Board of Nursing on 3/11/2024 and confirmed receipt on 3/11/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 8:21 AM, in an interview with the NHA, he described that as soon as an allegation of abuse was identified, the facility suspended the involved staff and started the investigation. He added that other residents and staff members were also interviewed, a one on one education to the involved staff members as well as house wide education was also conducted. On 4/4/25 at 10:08 AM, during an interview with GNA #9, he/she stated that the facility expected the staff to immediately report any kind of abuse to the administrator. He/she added that he/she had received online and regular classroom abuse trainings. On 4/4/25 at 10:10 AM, in an interview with LPN # 4, he/she stated that the staff had a couple of hours to 24 hours to report an abuse to the Unit manager, the Supervisor or the Administrator. He/she added that he/she had received abuse trainings either in classroom or on videos. On 4/9/25 at 12:23 PM, during an interview with the NHA, the [NAME] President of Operations and the Regional Clinical Nurse Consultant, the surveyor informed them that Resident 105's incident was considered Past Non- Compliance.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on surveyor record review, interviews with facility staff and Residents, it was determined that the facility failed to revise Resident care plans and conduct timely care plan meetings. This was found to be evident in 4 (Resident #10, 41, 93, and 106) out of 4 Residents reviewed for timing and revision of care planning. The findings include: 1) On the initial tour of the facility 03/31/2025 at 09:58 AM Resident #10 stated that he/she remembered attending one care plan meeting last summer and does not recall having received invitations for care plan meetings. Resident stated, I have been here for 2 years. A care plan is a document that outlines a person's healthcare or support needs, how those needs will be met, and by whom. It serves as a roadmap for providing consistent and effective care. The care plan helps organize and prioritize caregiving activities, ensures continuity of care, and promotes collaboration among healthcare providers. It is a vital tool for effective and personalized care. It ensures that individuals receive the right support, at the right time, and from the right people, ultimately improving their well-being and quality of life. The surveyor conducted a record review of Resident #10's medical record on 04/02/2025 at 09:30 AM. During the review of the medical record, it revealed that there were two care conference notes in the progress note section of the electronic medical record dated 05/22/2024 and 12/19/2024. Both care conference notes indicated that Resident #10 and his/her son attended the care conferences. However, there were no meetings held for February of 2024, August of 2024 and March of 2025. Additionally, there was a care plan attendance sheet located in the miscellaneous section of Resident #10's electronic medical record dated 12/19/2024 with Resident's signature on the sheet. There were no other care plan attendance sheets located in the electronic medical record for Resident #10 for the past year. In an interview with the Licensed Nursing Home Administrator (LNHA) on 04/02/2025 at 10:08 AM the surveyor requested care plan attendance sheets and care plan meeting notes for the past year for Resident #10. At 11:05 AM, the LNHA provided the surveyor with the care conference note and attendance sheet for 12/19/2024 and stated that was all the documentation that was found. In an interview with the Regional Social Worker on 04/03/2025 at 11:10 AM the surveyor conveyed to the Regional Social Worker that the only care plan meeting documentation for the past year was for December of 2024 for Resident #10. The Regional Social Worker stated that she would investigate this. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the follow-up interview with the Regional Social Worker at 12:30 PM on 04/04/2025 she provided the surveyor with the care conference notes for 05/22/2024 and 12/19/2024 and the care plan attendance sheet for 12/19/2024 for Resident #10. The Regional Social Worker acknowledged that there was no additional documentation on care planning meetings for the past year for Resident #10. The surveyor asked the Regional Social Worker what the expectation was for the care plan meeting process. The Regional Social Worker stated that written invitations were mailed to the Resident Representatives and given to the Residents, the attendance sheets were maintained in the miscellaneous section of the electronic medical record and the care plan meeting note was documented in the progress note section of the electronic medical record. 2) The surveyor conducted a record review of Resident #93's medical record, specifically the care plan on 04/02/2025 at 10:06AM. Review of Resident #93's care plan revealed that Resident had a care plan for anticoagulant therapy (blood thinner) dated 08/28/2024 with a revision on 09/11/2024 and a target date of 05/30/2025. Review of the physician orders revealed that there was no current physician order for anticoagulant therapy for Resident #93. According to the discontinued orders for Resident #93, the anticoagulant therapy (Lovenox) was discontinued on 10/15/2024. The surveyor interviewed the Regional Clinical Nurse Consultant (RCNC) at 09:50 AM 04/07/2025 regarding Resident #93's care plan and anticoagulant therapy. The surveyor conveyed to the RCNC that Resident #93 had a current care plan for anticoagulant therapy and that there was not a current physician order for an anticoagulant medication and that the anticoagulant medication was discontinued 10/15/2024. The RCNC reviewed Resident #93's physician orders and care plan and acknowledged the surveyor. The RCNC stated that Resident #93 was no longer receiving an anticoagulant medication (Lovenox), the medication was discontinued on 10/15/2024, and the care plan should have been resolved. A low air loss mattress (LAL) is a medical-grade mattress designed to prevent and treat pressure injuries by reducing moisture and health buildup. The LAL mattress uses a system of inflated air cells that continuously circulate air, providing a dry, comfortable sleeping surface that delivers consistent pressure redistribution. Pressure ulcers are injury to the skin and underlying tissue resulting from constant and prolonged pressure on the skin. This pressure can lessen blood flow to the affected area, which may lead to tissue damage and tissue death. Venous ulcers (stasis ulcers) are open wounds on the leg or ankle caused by abnormal or damaged veins due to poor circulation and high pressure in the veins. Arterial ulcers (ischemic ulcers) are painful skin wounds caused by poor blood circulation and inadequate blood supply to the lower extremities. 3) The surveyor conducted a review of Resident #41's medical record on 04/07/2025 at 08:10 AM. Review of Resident #41's medical record revealed that Resident #41 had a physician order for a low air loss mattress (LAL). Further review of the medical record revealed that Resident had care plans for pressure ulcers, arterial ulcers, venous ulcers and skin impairment that were resolved but remained on the current care plan. Review of the current physician orders for Resident #41 revealed that there were no treatment orders for any ulcers. In addition, Resident #41 had a care plan for an antiplatelet medication (inhibits blood clots), but review of Resident #41's physician orders revealed that there was not a current order for antiplatelet medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON) at 11:05 AM on 04/07/2025 the surveyor conveyed to the DON that Resident #41 had a care plan for an antiplatelet medication but did not have a physician order for an antiplatelet medication. The DON reviewed Resident #41's physician orders and care plan and acknowledged that Resident did not have an order for an antiplatelet medication but had a care plan for antiplatelet medication. The surveyor conducted an interview with the East Wing Nurse Unit Manager (UM) on 04/07/2025 at 12:55 PM. During this interview, the surveyor conveyed to the UM that Resident #41 had care plans for pressure, arterial and venous ulcers and these care plans were resolved but remained on the current care plan, and that there were no physician orders for wound treatment for these ulcers. The UM acknowledged the surveyor and confirmed that Resident #41 did not have any ulcers at present and all previous ulcers were healed, and that the care plan should have been revised to reflect Resident #41's current skin condition. No additional information was provided by the facility at the time of exit. 51491 Care Plan meetings are meetings with a team of care providers including the attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of food and nutrition services, the resident, and the resident ' s representative if applicable to ensure the care plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. 4) During a telephone interview with the family of Resident #106 on 4/03/25 at 5:31 PM he/she reported having difficulty scheduling Care Plan Meetings with the Interdisciplinary Team. During a review of Resident #106 Electronic Medical Records (EMR) on 4/04/25 at 07:45 AM it was discovered that Resident #106 was admitted to the facility on [DATE] and discharged on [DATE]. The following Care Plan meetings were found in the EMR. On 11/16/23 a Care Plan Meeting was held. The sign-in sheet shows the attendees were the Social Worker, Director of Rehab, Nursing and family members. On 2/08/24 a Care Plan Meeting was held. The sign-in sheet shows the attendees were the Director of Rehab, Activities Director, Ombudsman, Registered Dietician, Unit Manager and family members. On 5/17/24 a Care Plan Meeting was scheduled but the family did not attend. The facility planned to reschedule. There were no additional Care Plan meetings documented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Regional Social Worker on 4/09/25 at 2:28 PM, the social worker was notified of the limited documentation of Care Plan Meetings and attendance rosters for Resident #106. She reported Care Plan meetings are done quarterly and would expect a Care Plan Meeting note to be documented along with an attendance sign in sheet to be scanned into the EMR when the Care Plan meeting occurred. She stated if the documents are not in the EMR, maybe they are in medical records and not uploaded yet. She advised she would attempt to find additional Care Plan documentation. During an interview with the Regional Social Worker 4/10/25 at 11:13 AM the Social Worker reported she was unable to find any additional Care Plan documentation for Resident #106.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 51899 Based on record review and facility staff interview, the facility failed to 1) assess a Resident with an actual fall and 2) document a witnessed fall. This was evident for 1 (resident #445) of 1 resident reviewed for quality of care. The findings include: A fall is defined as an unintended descent to the floor or other lower surface, with or without injury to the resident or patient. This includes slips, trips, or loss of balance, whether witnessed or not, and whether or not the individual is able to get up without assistance. A fall assessment is a systematic process used by healthcare professionals to identify a patient's risk of falling and to determine contributing factors. It typically involves evaluating medical history, medications, cognitive status, mobility, gait, balance, and environmental risks. The goal is to guide the development of individualized interventions to prevent falls and improve patient safety. A nursing care plan is a structured, written document that outlines the nursing care to be provided to a patient, tailored to their specific healthcare needs and goals. It serves as a comprehensive guide for nurses, detailing the assessment, diagnosis, interventions, and outcomes related to the patient's health status. Nursing care plans are dynamic documents that evolve as the patient's condition changes, allowing for ongoing assessment and modification of the care provided. During a medical record review conducted on 4/19/25 at 7:30 AM, it was revealed that Resident #445 experienced a witnessed fall on 12/16/24. The resident ' s medical record revealed no documentation of an incident report related to the fall, post-fall assessment and revision or update to the resident ' s fall care plan to reflect the incident and resident condition. During an interview with the Regional Clinical Nurse Manager (RCNM) on 4/9/25 at 11:43 am, the RCNM acknowledged that fall assessments were required to be completed following resident falls. However, he confirmed that in the reviewed case, the facility did not complete the required fall assessment, nor was the resident ' s care plan revised to reflect the fall incident.