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	04/21/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record reviews and interviews it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) were provided with annual performance evaluations and skills competencies. This was found to be evident for 4 (GNA #9, #10, #11, #13) out of 5 GNAs reviewed for performance evaluations and skills competencies reviewed during the recertification and complaint survey. The findings include: During a review of employee files conducted on 04/16/26 at 11:42 AM it was discovered that GNAs #9, #10, #11, and #13 did not have documentation of a current annual performance evaluation and skill competencies. During an interview conducted on 04/17/26 at approximately 10:00 AM the Regional Director of Operations (RDO)# 8 reported that the facility has had recent changes in the Human Resource department and Staff Educator/ Assistance Director of Nursing (ADON). As a result, the facility had been unable to locate the performance evaluations and skills competencies. The RDO stated that this is an opportunity to identify an area of improvement.During an interview conducted on 04/17/26 at approximately 10:30 AM the Director of Nursing (DON) reported that she recently held a skills clinic with return demonstration for GNAs. The Surveyor requested the documentation for GNA #9, #10, #11, #13, and #26 skill competencies. The DON returned on 04/17/26 at approximately 11:30 AM with GNA #26's employee file and skill competencies. She stated that the GNA skill clinic did not go so well that although it was mandatory GNAs elected not to attend. The DON also stated that next year will be better. The DON further reported that she would provide skill competencies for GNAs #9, #10, #11, and #13.As of exit date on 04/21/26 the DON had not provided the Surveyor skill competencies for GNA #9, #10, #11, and #13.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, it was determined that the facility failed to properly store and label medications. This was evident in 1 of 1 medication room and 2 of 2 medication carts observed during the recertification survey process.The findings include:On 04/15/2026 at 1:49 PM during an observation conducted with Licensed Practical Nurse (LPN) #20 in the East Wing 1 medication room, the following was observed:Two bags of Heparin (30,000 units/1000 mL Normal Saline) labeled for Resident #8 were stored in the medication room refrigerator. Review of the pharmacy labels revealed use-by dates of 02/27/2026 and 03/02/2026; both medications were observed beyond their labeled use-by dates.One bag of Heparin (30,000 units/1000 mL Normal Saline) labeled for Resident #8 was observed stored on a shelf in the medication room. Review of the medication label indicated that refrigeration was required; however, the medication was not stored in accordance with labeled instructions.One vial of Tuberculin Purified Protein (5 IU/0.1 mL) was observed opened without a documented date of opening, making it unable to determine the appropriate use period and stability after opening.On 04/15/2026 at 1:55 PM during an observation conducted with LPN #20 of the East Wing 1 medication cart, the following was observed: Aspirin 81 mg (1 bottle), Pain Relief (Tylenol) 325 mg (1 bottle), Senna-Plus (1 bottle), Tylenol Regular Strength 325 mg (1 bottle), and Risperidone Oral Solution 1 mg/mL (1 bottle) were opened without documentation of the date opened. On 04/15/2026 at 2:09 PM during an interview, LPN #20 stated that medications are required to be labeled with the date upon opening. LPN #20 confirmed that the above-mentioned medications were opened without a documented date, making it unable to determine when the medications were opened. On 04/15/2026 at 2:15 PM, during an observation conducted with LPN #21, of the East Wing 2nd medication cart, the following was observed: Folic Acid 400 mcg (1 bottle), Zinc 50 mg (1 bottle), Geri-Kot 8.6 mg (1 bottle), Non-Aspirin Extra Strength (1 bottle), Iron (Ferrous Sulfate) (1 bottle), Bisacodyl 5 mg (1 bottle), and Probiotic (1 bottle) were opened without documentation of the date opened. On 04/15/2026 at 2:22 PM during an interview, LPN #21 stated that bottle medications are required to be labeled with the date upon opening. LPN #21 confirmed that the observed medications were opened without a label indicating the date of opening.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure completion of required Preadmission Screening and Resident Review (PASARR) prior to admission. This was evident for 1 of 1 resident reviewed (Resident #14).The findings include:Preadmission Screening and Resident Review (PASARR) is a federal requirement that ensures individuals with serious mental illness or intellectual disabilities are evaluated prior to nursing home admission to determine appropriate placement and services. A Level I PASARR is an initial screening to identify potential need, and a Level II PASARR is a comprehensive evaluation required when the Level I screen is positive.On 04/15/2026 at 11:00 AM, this surveyor conducted a record review of Resident #14's Level I PASARR screening, completed on 03/09/2026, which indicated the need for a Level II PASARR evaluation. Resident #14 was admitted to the facility on [DATE]; however, record review revealed no documentation of a completed Level II PASARR in the resident's chart.On 04/15/2026 at approximately 11:15 AM, continued record review of the Social Services assessment dated [DATE] documented No in response to whether the resident was considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability, despite the Level I screening indicating the need for further evaluation.On 04/16/2026 at approximately 12:00 PM, this surveyor requested documentation of the Level II PASARR screening for Resident #14; the facility was unable to provide evidence that the screening had been completed.On 04/20/2026 at 10:55 AM, this surveyor conducted an interview with Admissions staff, who reported that PASARR screenings are expected to be completed prior to admission, typically by the hospital. She further stated that if a resident is admitted without a completed PASARR, the facility is responsible for ensuring completion, and that identification of a required Level II PASARR should occur within 24-72 hours of admission.On 04/20/2026 at 11:53 AM, this surveyor conducted an interview with the Administrator, who acknowledged that the facility accepted Resident #14 without verifying completion of the required Level II PASARR and stated that this had been overlooked. It was communicated that accepting a resident prior to completion of the PASARR process is a concern. The Administrator acknowledged and confirmed understanding.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, record review, and interviews it was determined the facility failed to provide an activities program to meet the needs and preferences for 1 resident. This was evident for 1 (Resident #36) of 1 resident reviewed for activities during the recertification survey and complaint survey.The findings include:On 04/15/2026 at 02:18 PM, an observation was made of Resident #36 laying in bed with the TV pushed against the back wall behind the headboard of their bed. There were no other forms of activity or engagement observed in the resident's room.On 4/17/2026 at 11:53 AM, observed Resident #36 resting in bed and tv was pushed back against the wall. No other forms of activity or engagement were observed in the room. On 04/17/2026 at 12:16 PM, a review of Resident #36 documented activities in their medical record for a 30 day look back revealed the Resident was documented as watching TV for all the days except for 3/28/2026.Care plans provide direction for individualized care of the residents. A care plan is a guide that holistically addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 4/20/2026 at 8:57 AM, a review of Resident #36's care plan showed the resident's preferred activities were socializing with other residents and staff on a daily basis, drinking hot tea, and socializing during the coffee klatch program.Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons.MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's condition.Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function of a resident and is a required screening tool used in the nursing homes to assess cognition. A score of 13-15 points indicates intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition.On 04/20/2026 at 12:52 PM, a review of Resident #36 medical records revealed the Resident had multiple medical problems that included but were not limited to dementia and palliative care. A review of the Minimum Data Set (MDS) with an assessment date of 04/06/2026, confirmed Resident #36 had a score of 2 out of 15 on the Brief Interview of Mental Status (BIMS) indicating severe cognitive impairment.During an interview conducted on 04/17/2026 at 1:31 PM, the Surveyor and Activity Director reviewed Resident #36's documented 30-day period of activities which showed TV watching as the only activity with the exception of 03/28/26. The Activity Director confirmed that the Resident was not a TV viewer. When asked what type of 1:1 activities the Activity Department had to offer residents, the Activity Director stated that her activity assistants would go around to the resident rooms and offer a variety of 1:1 and independent activities based on different types of mental stimulation. The Surveyor discussed the concern that Resident #36 had not received the care planned activities. The Activity Director acknowledged that the resident had not received activities based on their assessed preferences and cognitive abilities. On 04/21/2026 8:06 at AM, an interview with the Nursing Home Administrator (NHA) confirmed that Resident #36 does not watch TV and can become agitated if it is pulled away from the wall in and in the resident's sight. Discussed concerns with NHA that the Activity Department had documented watching TV as the primary activity offered to Resident #36 for 29 days out of 30 days that were reviewed.

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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. Based on record reviews and interviews, it was determined the facility failed to maintain Quality of Care. This was evident for 1 (#8) out of 1 Resident evaluated for quality of care during the recertification survey.The findings include:Necrotic refers to the death of cells or tissues, usually appearing as black, brown, or discolored hardened skin (eschar) or wet, sloughing tissue. Gangrene is a serious, potentially fatal condition involving tissue death (necrosis) caused by infection or lack of blood flow. Symptoms include skin discoloration (blue/black/red), pain, numbness, and foul-smelling blisters. Treatment requires immediate medical attention, often antibiotics, surgery to remove dead tissue, or amputation, alongside hyperbaric oxygen therapy.During a review of Medical Record for Resident #8 on 4/20/2026 at 1:35 PM a Nurse Practitioner Progress note written on 2/16/2026 was discovered which reported, noted necrotic toes on second and third toes on left foot - Vascular surgery consult.A Vascular Surgery consult progress note written on 2/19/2026 was found that reported Left second toe discoloration: May be dry gangrene but palpable pedal pulse. No need for further vascular workup with no correctable vascular lesion and Recommend podiatry consultation.An order was placed for a Podiatry consult on 2/26/2026. The order for Podiatry consult was signed off on the Treatment Administration Record on 2/27/2026. There was no documentation of a podiatry referral or consult being completed in the medical records for Resident #8 for the months of February or March.Continued medical record review for Resident #8 revealed a Nurse Practitioner progress note dated 4/08/2026 which reported the Wound Nurse Practitioner on 4/07/2026 documented stable dry gangrene eschar of left second and fifth toes and left lateral foot with palpable pulse and recommended Vascular evaluation and added the Vascular Surgery provider was reconsulted who made a recommendation for a podiatry consult.Further review of the medical records revealed a physician progress note on 4/09/2026 that reported New warmth, swelling, and light drainage of fifth toe and diagnosed cellulitis. It also identified left foot gangrene with eschar on the second, fifth toes and left lateral foot with palpable pulse. An additional order to Schedule Podiatry consult for 2nd and 5th toe discoloration was written on 4/09/2026. Further medical record review it was discovered that the Podiatrist assessed Resident #8 on 4/14/2026 and recommended the Resident go to the emergency room for further evaluation. Additional medical Record review showed that Resident #8 was transferred to the hospital for significant gangrenous changes to left foot per Podiatrist recommendation. He/she was admitted to the hospital for gangrene of the foot.Osteomyelitis is a serious, often bacterial infection of the bone, causing pain, swelling, and fever.Further medical record review of the hospital records showed the Resident had multiple toes that appeared gangrenous and x-rays were obtained which showed soft tissue swelling with no osteomyelitis, but antibiotics were given as a precaution. A surgical consult note reported the resident had stable dry gangrene to left foot and had no signs of infection right now. Podiatry evaluated the Resident in the hospital and did not recommend any surgical intervention.During an interview with the Transportation Coordinator #27 on 4/20/2026 at 2:49 PM she reported that she handled appointment scheduling and arranging transportation to the appointment. She reviewed the schedule log and found Resident #8 had an appointment with the Podiatrist on 4/09/2026 at 9:45 AM and was unable to find any additional Podiatry Appointments requested or made for Resident #8. During an interview with the Director of Nursing (DON) #2 on 4/20/2026 at 4:10 PM she reported that the only documentation found for Resident #8 having a podiatry consult completed was on 4/09/2026. She confirmed that she did not find any documentation for the consultation occurring in February or March. During an interview with Unit Manager #17 on 4/20/2026 at 4:36 PM he reported that if there were orders for a Resident was referred to have a consult with another doctor. The process would be for the Nurse who saw the order and confirmed the order would place the referral request on the Communication Board in the computer. The Transportation Coordinator would then schedule the appointment and transportation. He reported that he was not sure what happened to the referral order, but it didn't look like the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process was followed through. During an interview with DON #2 on 4/21/2026 at 7:07 AM she reported the order for Resident #8 looked like it had been missed. She reported she would check to see if a referral had been made to a Podiatrist that would provide on-site healthcare services to the Resident through the HealthDrive Cooperation. During a review of the HealthDrive Podiatry Group Schedule on 4/21/2026 at 9:31 AM it was confirmed that Resident #8 had not been seen by the HealthDrive Podiatrist during the months of February and March.

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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 and interviews it was determined that the facility failed to ensure staff perform appropriate hand hygiene. This was evident for 1 Licensed Practical Nurse (LPN #21) of 1 LPN observed for hand hygiene during the recertification survey and complaint survey.The findings include:Hand hygiene is mandatory before putting on gloves and immediately after removing gloves to prevent cross-contamination, as gloves are not a substitute for hand hygiene. Health care workers must change gloves and perform hand hygiene when moving from a soiled to a clean body site on the same patient, or between patient contacts. The proper terms for putting on medical gloves are donning and taking off medical gloves is doffing.An observation of Resident #2's wound care was conducted on 4/20/2026 at 1:34 PM. The Surveyor observed LPN #21 provide wound care for the Resident. During the wound care observation the LPN removed the old bandage from the wound and then changed gloves however the LPN failed to perform hand hygiene between glove changes. The LPN cleansed the wound and proceeded to pack the wound without changing gloves between the cleansing of the wound and applying the clean dressing. The LPN failed to change gloves when she moved from a soiled to clean procedure. During the continued observation LPN #21 failed to perform hand hygiene when she donned a new pair of gloves after the wound care was completed. The LPN removed the old bandage on the next wound and changed gloves however she failed to perform hand hygiene between the glove change. The LPN cleaned the wound, removed her gloves and failed to perform hand hygiene before donning a new pair of gloves to place the clean dressing and bandage on Resident #2s wound. On 04/20/2026 at 3:19 PM, an interview with LPN #21 confirmed she did not perform hand hygiene between glove changes. On 04/20/2026 at 3:51 PM, the findings of the observation were reported to The Director of Nursing and the Nursing Home Administrator.