STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215052	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Springbrook	12325 New Hampshire Avenue Silver Spring, MD 20904

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on interviews and record review it was determined that the facility failed to develop and implement a comprehensive care plan to meet the needs of a Resident. This was found evident of 1 (Resident #85) of 19 Residents reviewed for care planning during an annual and complaint survey. The findings include: On 3/14/25 at 8:18 AM, the surveyor reviewed Physical Therapy (PT) notes for Resident #85. The review revealed a note written on 1/21/25 that stated, Resident # 85 was educated and engaged in bilateral (both) lower extremities home exercise program to improve strength. It further stated that the Therapist communicated with the unit manager about the Resident's inability to see and hear. On 3/14/25 at 12:30 PM, the surveyor reviewed Resident #85's Minimum Data Set (MDS) assessment dated [DATE] and 1/21/25. The review revealed that on 10/15/25 Resident #85 was assessed to have adequate hearing ability and on the 1/21/25 Resident #85 was assessed to have minimal difficulty (difficulty in some environments, such as when a person speaks softly or setting is noisy). On 3/14/25 at 2:40 PM, the surveyor reviewed Resident # 85's January Medication Administration Record (MAR) during the review it was revealed that Resident #85 has an order written on 1/20/25 at 9:20 PM for debrox otic solution with the indication for cerumen impaction (a medical term for earwax blockage) in the left ear. The surveyor next reviewed Resident #85's care plan. No care plan was developed regarding hearing or vision deficits for resident #85. On 3/14/25 at 3 PM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor relayed the concerns that Resident #85 was identified as having hearing and vision difficulties and no care plan or interventions were written for these identified needs.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44440 Based on observations, record reviews, and staff interviews, it was determined that the facility failed to ensure medications were administered to a resident as ordered. This was evident for 6 (Resident #77, #7, #38, #48, #90 & #85) out 14 residents reviewed for medication regimen review and medication administration. The findings include: 1a) On 3/7/25 at 10:46 AM the surveyor observed Licensed Practical Nurse (LPN) #14 prepare medications that were scheduled to be given at 9 AM for Resident #77. LPN #14 stated that lactulose was not available but had 2 of the medications, amlodipine Besylate and Loratadine. The surveyor next observed LPN #14 administer the medications to Resident #77 at 10:51 AM. The surveyor noted this was over an hour from the due time. 1b) On 3/7/25 at 10:56 AM the surveyor observed Licensed Practical Nurse (LPN) #14 prepare medications that were scheduled to be given at 9 AM for Resident #7. LPN #14 stated that fluticasone furoate-vilanterol inhaler and furosemide were not available and had to be re-ordered. Ferrous sulfate, folic acid, extra strength tylenol, metoprolol tartrate, lubiprostone, escitalopram oxalate, clopidogrel bisulfate, allopurinol, letrozole and lactulose oral solution were prepared. The surveyor next observed LPN #14 administer all the medications administered to Resident #7 at 11:13 AM except the lactulose in which the resident refused. The surveyor noted this was over an hour from the due time. At 11:30 AM, the surveyor reviewed Resident #7's March Medication Administration Record (MAR). Flonase nasal suspension was additionally documented as not available for the 9 AM administration on 3/7/25. On 3/7/25 the surveyor interviewed the acting Director of Nursing (DON) and LPN #14. During the interview the surveyor reviewed that the two residents observed for medication administration both had medications that were ordered but not given because they were not available. The acting (DON) stated that the facility had some ability to pull missing medication from an emergency supply and would look into the issue. 1c) On 3/13/25 at 5:48 AM, the surveyor observed License Practical Nurse (LPN) #15 prepare Resident #38's medication that was due to be given at 6 AM. LPN #15 crushed the levothyroxine sodium tablet and while in the room mixed the medication with water. LPN #15 next pulled the medication into a syringe, paused Resident #38's tube feeding, opened the medication port of Resident #38's gastric tube (a tube inserted through the abdominal wall and leads to the stomach), pushed the medication into the tube with the syringe, closed the medication port and restarted the tube feeding. On 3/13/25 at 7:04 AM, the surveyor reviewed Resident #38's orders. The review revealed an order written on 2/25/25 that stated, flush Resident #38's tube with at least 15 ML of water after final medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 7:13 AM, the surveyor interviewed LPN #13. During the interview she confirmed that she did not flush the tube with water but would do it now. 1d) On 3/13/25 at 10:15 the surveyor observed Registered Nurse (RN) #19 prepare medications that were scheduled to be given at 9 AM for Resident #48. RN #19 stated that clopidorel was not available but had 5 of the medications, aspirin, carvedilol, fluoxetine hydrochloride, hydralazine hydrochloride, ferrous sulfate. The surveyor next observed RN #19 administer the medications to Resident #48 at 10:32 AM. The surveyor noted this was over an hour from the due time. 1e) On 3/13/25 at 10:49 AM the surveyor interviews Licensed Practical Nurse (LPN) #16. During the interview LPN #16 stated that Resident #90 returned from a therapy session and that she would be giving his/her 9 AM medications. LPN #16 stated that the ncruse ellipta inhaler and acamprosate calcium were not available and would have to be ordered. LPN #16 prepared Resident #90's gabapentin, thiamine, prednisone, furosemide, apixaban, fluoxetine hydrochloride, folic acid, cilostazol, and budesonide-formoterol fumarate inhaler. On 3/13/25 at 11:22 AM, LPN #16 administered the mediations to Resident #90. This was 33 minutes after the resident got back from therapy when the medications were due to be given at 9 AM. The surveyor reviewed the policy titled: Medication Administration. Number 12 in the explanations and compliance guidelines stated; Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. On 3/13/25 at approximately 1:30 PM, the surveyor reviewed the concerns with the acting DON that multiple residents did not have medications available to them and were not given with medications administration observed. The surveyor also reviewed the concern that on multiple occasions medications were given well over an hour after they were due to be given. 1f) On 3/14/25 at 2:40 PM, the surveyor reviewed Resident # 85's January Medication Administration Record (MAR) during the review it was revealed that Resident #85 has an order written on 1/20/25 at 9:20 PM for debrox otic solution with the indication for cerumen impaction (a medical term for earwax blockage) in the left ear. The medication was to be given twice a day for 4 days. On further review of the MAR it was noted that the 9 AM dose was marked at a 7 see progress notes and the 5 PM dose was left blank. Both doses for the next three days were documented as given. The review revealed that Resident #85 got the medication for 3 days instead of the 4 days prescribed. On 3/14/25 at 3:00 PM the surveyor conducted an interview with the acting Director of Nursing (DON). The acting DON confirmed the med was not administered as ordered.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 45733 Based on observation, meal ticket review and interview, it was determined that the facility staff failed to ensure the residents' food preferences were honored. This was found to be evident for 1(Resident #9) out of 38 residents reviewed for food/nutrition. The findings include: Observation of the kitchen serving lunch, on 03/12/25 at 11:40 AM, found that East unit #1 food cart arrived at 11:43 AM in the hallway. Resident #4 refused his lunch tray containing rice, he stated because he dislikes rice. Reviewing his meal ticket revealed that no rice was printed on his meal tickets. Shared above info. with the Kitchen's Manager (Staff #4) that he agreed it was an error. Interview, on 03/12/25 at 01:20 PM, the Administrator stated that he agreed to the error that kitchen staff made as a deficiency practice.