| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215052 | A. Building<br>B. Wing | 12/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Springbrook | 12325 New Hampshire Avenue<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, facility staff interviews, the facility failed to provide medication administration that meets professional standards for 5 of 8 sampled residents reviewed for medication administration. (Resident #27, Resident #23, Resident #28, Resident #29 and Resident #30). 1. Resident #27 was admitted to the facility on [DATE] with a diagnosis of diabetes. A review of the physician's orders dated 11/22/25 revealed Resident #27 was prescribed insulin lispro injection solution; inject as per sliding scale if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units Blood sugar above 400, give 7 units. Repeat Blood Sugar in 15 minutes and call provider., subcutaneously before meals and at bedtime for diabetes. A medication administration observation was conducted on 12/16/25 at 11:49 am with Staff Nurse #6. Staff Nurse #6 was observed checking Resident #27's blood glucose level. Staff Nurse #6 indicated that Resident #27's blood glucose was 167mg/dl and required insulin coverage of 2 units of insulin lispro per sliding scale orders. Staff Nurse #6 noted to obtain insulin lispro kwikpen (Humalog) which is a prefilled, disposable pen delivering rapid-acting insulin to manage blood glucose levels for diabetes by working quickly (within 15mins) to lower glucose levels. Staff Nurse #6 was observed, donning gloves, getting the insulin lispro kwikpen and an insulin syringe. Staff Nurse #6 was observed inserting the insulin syringe into the rubber portal for the insulin lispro kwikpen and extracting 2 units of insulin, into the insulin syringe. Staff Nurse #6 was then observed , administering 2 units of insulin lispro, using the insulin syringe into Resident #27's upper arm. Upon observation of the insulin lispro kwikpen, it was noted that it did not have any labels, only for hand written dates of 12/10/25 to 1/7/26 and room [ROOM NUMBER]. The insulin lispro kwikpen did not have a label that indicated the name of resident, dose, route, or physician order. During interview on 12/17/25 at 12:33 pm, Staff Nurse #6 indicated that he used an insulin syringe to extract insulin from an insulin lispro kwikpen , due to lack of kwikpen compatible needles such as BD autoshield safety needle with dual automatic protective shield, in the facility. Staff Nurse #6 indicated that he had been using the insulin syringe for quite a while. Staff Nurse #6 could not state, the duration of using the in. Staff Nurse #6 indicated that he was aware that insulin syringes were not to be used on kwikpen, but had been asked to used the insulin syringes by the central supply manager. Staff Nurse #6 further indicated that he used an unlabelled insulin lispro kwikpen , to extract insulin for Resident #27. Staff Nurse #6 stated that the kwikpen, had a room number and the open and discard dates , manually hand written on the kwikpen, with a black marker. Staff Nurse #6 indicated that he did not require a label, with resident name, route and dose , because the room number indicated on the kwikpen, was enough to identify the resident. During Interview on 12/18/25 at 11:11 am, Staff Nurse #23 indicated that she used insulin syringes to extract insulin dosages from insulin pens/kwikpen. Staff Nurse #23 indicated that facility did not have a supply of the special safety needles used for the pens/kwikpens, such as the BD Autoshield safety needly. Staff Nurse #23 indicated that she was aware that insulin syringes could not be used to extract insulin from insulin pens/kwikpen, but had not choice since facility supplied insulin syringes weekly. During interview on 12/18/25 at 9:57 am, Staff Nurse #13 indicated that she had worked at facility for 6 months. Staff Nurse #13 revealed that since her employment, she was trained to use insulin syringes to extract insulin from insulin pens/kwikpens. Staff Nurse #13 stated that she questioned nursing staff about the use of insulin syringes. Staff Nurse #13 indicated that she was informed by nursing staff that facility did not have the special safety needles such as BD autoshields safety needles to use on the insulin pens/kwikpen. Staff Nurse #13 confirmed that she had used insulin syringes to extract insulin from insulin pens/kwikpen for at least 6 months. During interview on 12/18/25 at 10:33 am, Staff Nurse #5 indicated that she had used insulin syringe to extract insulin from insulin pens/kwikpens. Staff Nurse #5 indicated that she reported to the administration that facility did not have the special safety needles required to use on the insulin pens/kwikpen such as BD Autoshield safety pens, more than 8 months ago. During interview on 12/17/25 at 12:37pm, Pharmacist indicated that insulin syringes, could not be used to extract insulin from an insulin lispro kwikpen. Pharmacist confirmed that insulin pens/kwikpen, had special needles such as the BD autoshield safety needle, that were compatible for use. Pharmacist stated that if a facility did not have the proper needles compatible to use on an insulin pen/kwikpen, the facility would not withdraw insulin from the pen using an insulin syringe. Pharmacist further stated, that facility would have to order the special safety needs . Pharmacist indicated using an insulin syringe to extract insulin from an insulin pen/kwikpen, would cause damage to the internal |

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| Complete Care at Springbrook | 12325 New Hampshire Avenue<br>Silver Spring, MD 20904 |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, facility and pharmacy staff interviews, the facility failed to administer medication as ordered by the physician to meet the resident's need of 3 of 8 sampled residents reviewed for pharmacy services. (Resident #23, Resident #29 and Resident #30). a. Resident #23 was admitted to the facility on [DATE] with a diagnosis of seizures adjustment disorder, hypertension, diabetes and dysarthria. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. A review of the physician's orders dated 11/3/25 revealed Resident #23 was prescribed Biofreeze cool the pain external gel 4% (menthol topical analgesic) apply to right shoulder topically two times a day for pain. A medication administration observation was conducted on 12/16/25 at 9:22 am with Staff Nurse #5. Staff Nurse #5 was observed to not have administered the medication biofreeze cool the pain external gel 4%(menthol topical analgesic) to Resident #23 as per physician orders. During interview on 12/18/25 at 10:33 am, Staff Nurse #5 stated that she thought she administered the medication to Resident #23. b. Resident #29 was admitted to the facility on [DATE] with a diagnosis of polyneuropathy, diabetes mellitus, osteoarthritis, pain in the right knee, pain in the left knee, vitamin D deficiency, and anemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact. A review of the physician's orders dated 3/8/21 revealed Resident #29 was prescribed salonpas pain relieving patch 4 % (Lidocaine) apply to knees topically one time a day for pain. A medication administration observation was conducted on 12/17/25 at 10:02 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered salonpas pain relieving patch 4% (lidocaine) to Resident #29 per physician orders. A review of the physician's orders dated 3/8/21 revealed Resident #29 was prescribed vitron -C tablet 65-125 mg(iron vitamin C), 1 tablet by mouth one time a day for anemia. A medication administration observation was conducted on 12/17/25 at 10:02 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered vitron-c tablet 65-125 mg (iron vitamin C) to Resident #29 per physician orders. During interview with Staff Nurse #11 on 12/18/25 at 8:11 pm, it was revealed that vitron-c tablet 65-125mg was not available . Staff Nurse #11 indicated that she misunderstood the order for salonpas pain relieving patch 4% and administered lidocaine and prilocaine cream 2.5% instead. Staff Nurse #11 confirmed that Resident #29 did not receive Salonpas pain relieving patch 4% to both knees and vitron-c 65-125mg tablet per physician orders.c. Resident #30 was admitted to the facility on [DATE] with diagnosis of diabetes, right ankle and foot osteomyletis, and peripheral vascular disease. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact. A review of the physician's orders dated 11/5/25 revealed Resident #30 was prescribed Jardiance oral tablet (hypoglycemia medication) 25 mg , 1 tablet by mouth one time a day for diabetes. A medication administration observation was conducted on 12/17/25 at 10:27 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered Jardiance oral tablet to Resident #30 per physician orders. During interview with Staff Nurse #11 on 12/18/25 at 8:11 pm, it was revealed that Jardiance oral tablet 25mg was not available. Staff Nurse #11 confirmed that Resident #30 did not receive the medications. During interview on 12/17/25 at 12:37pm, Pharmacist indicated that Resident #23, Resident #29 and Resident #30 should have received their medications as per physician orders. During an interview with the Director of Nursing (DON) on 12/18/25 at 12:05 pm, she revealed that Resident #23, Resident #29 and Resident #30 should have received medications as per physician orders. She further stated that all nurses will be retrained on reordering medication timely. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>(continued on next page) |

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|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review , staff and pharmacist interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by 5 errors out of 43 opportunities observed. The medication error rate was 11%. 1. A review of the physician's orders dated 11/3/25 revealed Resident #23 was prescribed Biofreeze cool the pain external gel 4% (menthol topical analgesic) apply to right shoulder topically two times a day for pain. A medication administration observation was conducted on 12/16/25 at 9:22 am with Staff Nurse #5. Staff Nurse #5 was observed to not have administered the medication biofreeze cool the pain external gel 4%(menthol topical analgesic) to Resident #23 as per physician orders. During interview on 12/18/25 at 10:33 am, Staff Nurse #5 stated that she thought she administered the medication to Resident #23. 2. A review of the physician's orders dated 12/11/22 revealed Resident #28 was prescribed amlodipine besylate 2.5mg 1 tablet by mouth one time a day for hypertension at 9:00 am.A medication administration observation was conducted on 12/17/25 at 9:48 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered the medication Amlodipine 1 tab 2.5mg by mouth due to Resident #28 having low blood pressure. Staff Nurse #11 was observed taking the tablet out of the medication card and placing it into a medicine cup. Staff Nurse #11 then labelled another empty medicine cup, with Resident #28 room number room [ROOM NUMBER]-A). Staff Nurse #11 was observed taking the empty medicine cup and placing it over the medicine cup with the medication. Staff Nurse #11 was observed placing an unlabelled medication back into the medication cart. During interview on 12/17/25 at 9:48 am, Staff Nurse #11 indicated that she would hold the amlodipine 2.5mg tablet and keep it in the medication cart .Staff Nurse #11 indicated that she placed the 1 tablet in a medicine cup with the room number manually written. Staff Nurse #11 stated that she would return in two hours and recheck the blood pressure. If the blood pressure increased, she would administer the medication at that time. Staff Nurse indicated that she did not want to waste medication , but would keep in , unlabeled , until she needed it. During interview on 12/18/25 at 8:11 pm, Staff Nurse #11 revealed that she returned to Resident #28 at about 12 noon . Staff Nurse #11 confirmed that she administered to Resident #28 the medication that was placed in the medication cup, labelled with a room number. Staff Nurse #11 could not recall if the blood pressure had increased or not. 3. A review of the physician's orders dated 3/8/21 revealed Resident #29 was prescribed salonpas pain relieving patch 4 % (Lidocaine) apply to knees topically one time a day for pain. A medication administration observation was conducted on 12/17/25 at 10:02 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered salonpas pain relieving patch 4% (lidocaine) to Resident #29 per physician orders. Staff Nurse #11 was observed to have administered Lidocaine and prilocaine cream USP 2.5%/2.5% topically to Resident #29's knees. During interview on 12/18/25 at 8:11 pm, Staff Nurse #11 indicated that she misunderstood the order for salonpas pain relieving patch 4% and administered lidocaine and prilocaine cream 2.5% instead. Staff Nurse #11 confirmed that Resident #29 did not receive Salonpas pain relieving patch 4% to both knees , but administered Lidocain and prilocaine cream , which was the wrong medication. 4. A review of the physician's orders dated 3/8/21 revealed Resident #29 was prescribed vitron -C tablet 65-125 mg(iron vitamin C), 1 tablet by mouth one time a day for anemia. A medication administration observation was conducted on 12/17/25 at 10:02 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered vitron-c tablet 65-125 mg (iron vitamin C) to Resident #29 per physician orders.During interview with Staff Nurse #11 on 12/18/25 at 8:11 pm, it was revealed that vitron-c tablet 65-125mg was not available . Staff Nurse #11 confirmed that Resident #29 did not receive vitron-c 65-125mg tablet per physician orders.5. A review of the physician's orders dated 11/5/25 revealed Resident #30 was prescribed Jardiance oral tablet (hypoglycemia medication) 25 mg , 1 tablet by mouth one time a day for diabetes. A medication administration observation was conducted on 12/17/25 at 10:27 am with Staff Nurse #11. Staff Nurse #11 was observed to not have administered Jardiance oral tablet to Resident #30 per physician orders. During interview with Staff Nurse #11 on 12/18/25 at 8:11 pm, it was revealed that Jardiance oral tablet 25mg was not available. Staff Nurse #11 confirmed that Resident #30 did not receive the medications. During interview on 12/17/25 at 12:37pm, Pharmacist indicated that all residents should receive their medications as per physician orders. During an interview with the Director of Nursing (DON) on 12/18/25 at 12:05 pm, she revealed that all residents should receive medications as per physician orders. |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observations, and staff and pharmacist interviews, the facility failed to label opened insulin pens with the patient name, physician name, date used for 1 insulin pens for 1 of 3 medication carts reviewed for medication storage (West Wing Medication Cart). The [NAME] Wing Medication Cart was observed on 12/16/25 at 11:49 am in the presence of Staff Nurse #6. The observation revealed 1 opened and used insulin pen of Humalog (insulin lispro) that was stored with no label indicating patient name, physician name and order. The facility insulin pens policy copyright 2025, provided by the Director of nursing , indicated that Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date.During interview on 12/17/25 at 12:33pm, Staff Nurse #6 indicated that he used an unlabeled insulin lispro kwikpen , to administer insulin. Staff Nurse #6 stated that the kwikpen, had a room number, manually handwritten on the kwikpen, with a black marker. Staff Nurse #6 indicated that he did not require a label, because the room number manually written on the kwikpen, was enough to identify the resident. During an interview with the Director of Nursing (DON) on 12/18/25 at 12:05 pm, indicated that nursing staff should discard any unlabeled insulin pens and notify pharmacy to reorder new insulin pens that have labels. During interview on 12/17/25 at 12:37pm, Pharmacist indicated that all insulin pens must be labelled with the patient's name, physician name and date opened. Pharmacy consultant further stated that once insulin pen is opened, it should be labelled with the date opened. Pharmacy consultant also indicated that any opened, unlabeled insulin pens should not be used, but facility should notify pharmacy and order a new insulin pen. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and recorded reviews, the facility failed to provide a direct communication system which relays Resident(R) calls when assistance was needed to ensure appropriate response from staff members at a centralized staff working station for three Residents, R35, R36, and R37. The facility census was 78. Findings Include: Record review of the facility undated policy titled Call Lights, Accessibility and Timely Response documented, the purpose of the policy was to assure the facility equipped Residents with a call light at each Resident bedside, toilet and bathing area to allow Residents to call for assistance. Call lights will directly be relayed to staff member or centralized location to ensure appropriate response. Policy directed staff to ensure the call light was within reach and secured as needed. Policy further directed staff to report problems with a call light system immediately to the supervisor and or maintenance director and provide immediate or alternative solutions, such as (a bell or whistle) until the problem was remedied. 1. Record review of R35s face sheet (a document containing Resident information and data) revealed R35s admission date was [DATE]. Her diagnoses included Infectious Gastroenteritis and Colitis, Congestive Heart Failure, and Diarrhea. Record review of the R35s Care plan initiated on [DATE], documented R35 required assistance with activities of daily lining (ADLs) due to limited mobility and directed staff to encourage R35 to use a bell or a call light for assistance. Record review of R35s admission, Minimum Data Set assessment (MDS) dated [DATE], documented his/her BIMS score was 15 indication R35 was cognitively intact. Record review of the facility works orders dated [DATE] through [DATE] documented the following unfinished orders: 2768: Call light not working in room [ROOM NUMBER]A 2771: Call light not working in room [ROOM NUMBER] A 2772: Call light socket cover(broken) in room [ROOM NUMBER]A 2774: Call light not working in room [ROOM NUMBER]A and 133B 2776: Call light not working in room [ROOM NUMBER]A 28802: Call light not working in room [ROOM NUMBER] Record review showed the work orders were not completed or corrected. During observation and interview on [DATE] at 11:40 AM, showed R35 in bed in room [ROOM NUMBER]-A. R35 stated that his/her call light did not work. Observation of the call light showed that the call light socket was detached from the wall. The call light plug hanged loose against the wall. Further observation showed there was no manual call bell in the room. R35 stated it was hard to locate staff when he/she needed help. 2.Record review of R36s Care plan initiated on [DATE], documented R36 had a self-care performance deficit and required assistance with activities of daily lining (ADLs) due to limited mobility. The Care plan directed staff to encourage R35 to use a call light for assistance. Record review of R36s face sheet showed, R36 was admitted on [DATE]. His/her diagnoses included, Spinal Stenosis, Cervical region, Cerebrovascular Disease. Hearing loss and Shoulder and back pain. Record review of R36s quarterly, Minimum Data Set assessment (MDS) dated [DATE], documented, R36s BIMS score was 15, indicating R36 was cognitively intact. In section GG of the MDS, documented R36 was dependent on staff with activities of daily living. During observation of room [ROOM NUMBER]-B on [DATE] at 11:45 AM, showed R36 in bed watching television. Interview with R36 revealed he/she was the Resident Council President (RCP) and shared the room with R35. Observation showed there was no manual call bell in the room. R36 stated the call light had not worked for the last four months and explained it was difficult for staff to respond when assistance was needed. R36 concluded he/she did not believe staff cared. 3. Record review of R37s Care plan initiated [DATE], documented R37 had a self-care performance deficit and required assistance with activities of daily lining (ADLs) due to limited mobility. The Care plan directed staff to encourage R37 to use a call light for assistance. R37 was a fall risk due to lack of balance. Record review of R37s quarterly, Minimum Data Set assessment (MDS) dated [DATE], documented his/her BIMS score was 15, indicating R37 was cognitively intact. In section GG of the MDS, documented R37 was dependent on staff with activities of daily living. Record review of R37s Face sheet revealed R37 was admitted on [DATE]. R37s diagnoses included, End Stage Renal Disease, Adjustment Disorder, and Pressure Ulcer. During observation and interview on [DATE] at 11:50 AM, GNA15 walked into room [ROOM NUMBER] and stated she was not aware the call was broken and was detached from the socket. GNA15 pressed both call lights in room [ROOM NUMBER]-A and 133-B and stated both call lights were not working. GNA15 proceeded to room [ROOM NUMBER]-A and stated that the call light in room [ROOM NUMBER] A was not working. GNA 15 concluded that she would notify the administrator and the maintenance manager. During an interview on [DATE] at 1:37 PM the Maintenance Director (MD) 17 stated he was aware that some of the facility call lights |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews of observations and recorded reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for three Residents(R). R13, R33 and R34, when facility failed to replace a damaged and leaking commode toilet in R33 and R34s bathroom for several months and failed to provide a sanitary environment in R13s room. The census was 78.Findings Include: Record review of the facility undated policy titled Safe and Comfortable Environment dated 12/11/2024 and last reviewed on 2/11/2025 documented; in accordance with Residents rights, the facility will provide a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services will be provided to maintain a sanitary, orderly, and comfortable environment. The facility will minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to the Housekeeping Department. 1.Record review of R13s face sheet (a document containing Resident information and data) revealed R13 was admitted on [DATE]. R13s diagnoses included, Spastic Quadriplegic Cerebral Palsy, Spinal Stenosis and Adjustment Disorder. Record review of R13s quarterly, Minimum Data Set assessment (MDS) dated [DATE], documented R13s Brief Interview for Mental Status (BIMS) score was 14. Section GG section of the MDS documented R13 was dependent on staff with all activities of daily living (ADL). During observation and interview on 12/15/2025 at 10:40 AM, R13 was observed lying on the bed. Observation showed several dark spots and dried food droppings with black and brown substances across the wall. R13 stated that the facility did not take time to clean his room and walls and explained he/she wanted to go home and live independently. During an interview on 12/17/2025 at 11:30 AM, the House Keeping Director (HKD), HKD 18 stated R13s room will be thoroughly cleaned, and tiles will be replaced. 2.Record review of R33s face sheet showed R33 was admitted on [DATE]. R33s diagnoses included, Unspecified Dementia without Psychotic disturbance, Benign Prostatic Hyperplasia, and Chronic Kidney disease. Record review of R33s quarterly, Minimum Data Set assessment (MDS) dated [DATE], documented his/her BIMS were 5. Section GG of the MDS documented, R33 required substantial to maximum assistance with personal hygiene. During observation and interview on 12/17/2025 at 10:50 AM, showed R33 stood and pointed to the bathroom and pinched his/her nose. R33 had problems communicating and stated, it smelled really bad. Observation of R33s bathroom on 12/17/2025 at 10:55 AM noted a strong odor in the bathroom area. The stool area was covered with black and brown substances. The floor tiles were discolored and were stained with dark brown substances; the entire bathroom had a strong urine odor and human waste. The floor had missing and damaged tiles. 3.Record review of R34s face sheet, showed R34 was admitted on [DATE]. R34s diagnoses included, End Stage Renal Disease, History of falling and Alcohol Abuse, Congestive Heart Failure, and Adjustment Mood Disorder. Record review of R34s annual, Minimum Data Set assessment (MDS) dated [DATE], documented his/her BIMS were 15, indicating R34 was cognitively intact. Section GG of the MDS documented, R34 was independent with activities of daily living (ADLs). During an interview on 12/17/2025 at 11:15 AM, R34 stated the bathroom stool needed to be replaced. R34 stated the smell in the bathroom was overwhelming and had been going on for over two months. R34 stated the Maintenance Director and House Keeping Director were aware. R34 concluded he/she had been using staff bathrooms as he/she believed the facility was unable to fix the broken commode. During an interview on 12/17/2025 at 11:30 AM, the House Keeping Director (HKD) 18 stated R33 and R34s bathroom needed the entire floor to be replaced. According to HKD 18, the smell of urine came from the floor tiles and explained he had been treating the same bathroom serval times a day and was unable to get rid of the odor. HKD 18 concluded the administrator was aware. A record review of a facility work order dated 12/17/2025 showed a private plumber documented that the toilet bowl was repaired and recommended the facility to replace the toilet bolts and replace the toilet pipes. Based on interviews, observations, and recorded reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for three (R13, R33, and R34) of the 3 sampled residents. When the facility failed to replace a damaged, leaking commode toilet in R33 and R34 bathrooms for several months, and failed to provide a sanitary environment in R13's room. During an interview on 12/17/2025 at 11:30 AM, the Housekeeping Director (HKD) 18 stated that the entire floor in R33 and the bathroom in R34 needed to be replaced. According to HKD 18, the smell of urine emanated from the floor tiles, and he explained that he had been treating the same bathroom several times a day but was unable to get rid of the odor. HKD 18 concluded that the administrator was aware. During an interview on 12/17/2025 at 1:37 PM |