Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	04/07/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was the determined that the facility failed to report an incident involving a resident who had a serious injury of unknown source, where abuse or neglect had not been ruled out, to the Office of Health Care Quality (OHCQ) as required. This was evident for 1 (Resident #12) of 13 residents reviewed during a complaint survey.The findings include:The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs.On 04/01/2026 at 10:46 AM, a review of Resident #12's clinical record revealed that on 03/23/2026, Resident #12 had an unwitnessed event in the facility. The resident's spouse reported the resident's legs were hanging off the side of the bed and were put back in place. Staff did not witness the event, and the resident could not explain what happened. The resident complained of left leg pain and was sent to the hospital on [DATE] for further evaluation.A review of the Emergency Department (ED) Provider notes dated 03/24/2026 revealed diagnostic imaging that showed an acute left hip periprosthetic (around an artificial joint or implant) fracture, described as a new fracture in the left proximal femur (the thigh bone). The resident returned to the facility on [DATE].Further review of Resident #12's clinical record showed the facility documented that the resident did not have a fall in the facility, and the cause of the injury was not clearly known.On 04/03/2026 at 12:13 PM, during an interview, the Administrator confirmed the 03/23/2026 incident was not reported to OHCQ. The Administrator stated the facility believed the injury happened when the resident's spouse moved the resident's legs and did not consider the event reportable.The findings were discussed with the Administrator and Regional Director of Operations during the exit conference on 04/07/2026.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to complete a thorough and timely investigation of an incident involving a resident who had a serious injury of unknown source. This was evident for 1 (Resident #12) of 13 residents reviewed during a complaint survey.The findings include: On 04/01/2026 at 10:40AM, a review of Resident #12's clinical record revealed that on 03/23/2026, Resident #12 had an unwitnessed event in the facility. The resident's spouse reported the resident's legs were hanging off the side of the bed and were put back in place. Staff did not witness the event, and the resident was not able to explain what happened. The resident complained of left leg pain and was sent to the hospital on [DATE]. Review of Emergency Department (ED) records dated 03/24/2026 showed the resident had an acute left hip periprosthetic (around an artificial joint or implant) fracture. On 04/03/2026 at 11:13 AM, during an interview, the Administrator stated that Resident #12's 3/23/26 incident was discussed at a risk meeting and that he would provide the documentation for review. On 04/03/2026 at 12:02 PM, a review of facility risk meeting documentation showed the facility documented that Resident #12 did not have a fall in the facility. However, the facility did not determine how the injury occurred. Further review showed the incident was discussed on 03/31/2026. There was no evidence to show the facility completed a timely or thorough investigation at the time of the event. On 04/03/2026 at 1:45 PM, during an interview, the Administrator stated the facility believed the injury happened when the resident's spouse moved the resident's legs and did not complete additional investigation to determine the cause of injury. On 04/07/2026 at 11:35 AM, during a follow up interview with the Administrator and Regional Director of Operations, it was confirmed that the incident was discussed in the risk meeting and that no additional investigation was conducted to determine the cause of injury. The findings were discussed with the Administrator and Regional Director of Operations during the exit conference on 04/07/2026.

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) discharge assessments were completed for a discharged resident. This was evident for 1 (Resident #2) of 13 residents reviewed during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.On 4/1/26 at 12:12 PM a review of Resident #2's medical record was conducted and revealed Resident #2 was transferred to an acute care facility on 2/3/26. Review of MDS assessments in Resident #2's medical record failed to produce a discharge MDS assessment.On 4/1/26 at 12:15 PM an interview was conducted with the MDS Coordinator. The MDS Coordinator was asked about the discharge assessment and she stated, I did not do one. I have no clue how this fell off the radar.On 4/2/26 at 1:30 PM the Nursing Home Administrator was informed of the concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, it was determined that the facility failed to ensure implementation of care planned interventions necessary to prevent accidents for a resident identified as high risk for falls. This was evident for 1 (Resident #12) of 3 residents reviewed for accidents during the complaint survey.The findings include:On 04/01/2026 at 10:46 AM, Resident #12's clinical record was reviewed to reveal the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, altered mental status, hydrocephalus, seizures, intracranial injury, and muscle weakness.Review of Resident #12's care plan revealed the resident had a history of multiple unwitnessed falls, including 01/09/2026, 01/15/2026, 02/12/2026, and 02/19/2026. The fall care plan, initiated on 02/19/2026, included the use of a fall mat for fall prevention.Review of Resident #12's hospital Discharge summary dated [DATE] revealed the resident was transferred to the hospital on [DATE] following an unwitnessed fall and returned to the facility on [DATE] after receiving surgical treatment for a confirmed hip fracture.Review of Resident #12's fall risk evaluations completed on 01/09/2026, 01/16/2026, 02/12/2026, 02/23/2026, and 03/23/2026 revealed the resident was identified as high risk for falls on each assessment.Continued record review revealed that on 03/23/2026, Resident #12's spouse reported that the resident's legs were dangling off the side of the bed. Resident #12 complained of leg pain and was transferred to the hospital, where diagnostic testing confirmed a new left hip fracture. The resident returned to the facility on [DATE].On 04/01/2026 at 1:32 PM, an observation of Resident #12 revealed the resident lying in bed with no fall mat in place on the right side of the bed.On 04/02/2026 at 8:05 AM, a second observation of Resident #12 revealed the resident lying in bed without a fall mat in place on the right side of the bed.On 04/02/2026 at 10:43 AM, during an interview, Unit Manager (UM) #19 confirmed Resident #12 was a high fall risk and should have had a floor mat in place as indicated in the care plan.On 04/02/2026 at 10:50 AM, the surveyor observed UM #19 placing a fall mat on the floor at the right side of Resident #12's bed. During a follow-up interview, UM #19 stated the fall mat was obtained from the supply closet.On 04/02/2026 at 10:59 AM, during an interview, the Assistant Director of Nursing (ADON) confirmed Resident #12 had a care planned intervention for a fall mat and stated the intervention should have been in place. The ADON further stated that if a fall mat is included in the care plan, there should be a corresponding physician order.On 04/02/2026 at 12:02 PM, a review of Resident #12's physician orders revealed no active order for a fall mat.On 04/02/2026 at 12:54 PM, during a follow-up interview, the ADON confirmed there was no prior order for a fall mat and stated a physician order for a fall mat was written the same day on 04/02/2026.On 04/07/2026, the findings were reviewed with the Administrator and Regional Director of Operations during the exit conference.