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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Springbrook	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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on review of Minimum Data Set (MDS) Assessment material and interview with facility staff, it was determined that the facility failed to transmit MDS assessments within 14 days of completion of the assessment. This was evident for 5 (Resident #22, #41, #80, #47 and #58) of 7 residents reviewed during the annual survey. The findings include: 1.On 4/28/2026 at 12:05 PM information from the Centers for Medicare and Medicaid (CMS) regarding transmission of Minimum Data Set (MDS) Assessments were reviewed. The review revealed that the MDS was not transmitted timely. Resident #22 The assessment Assessment Reference Date (ARD) 4/13/26 was transmitted to CMS late. Resident #41 The assessment ARD 3/20/26 was transmitted to CMS late. Resident #80 The assessment ARD 4/13/26 was transmitted to CMS late. 04/30/2026 8:30 AM Staff #18, the Regional Director of Reimbursement, MDS was Interviewed and confirmed the above MDS assessments were overdue and were not transmitted timely. 2. On 04/29/2026 at 10:35 AM, review of Resident #47's medical record revealed the MDS completed on 4/13/2026 was transmitted late (more than 14 days after the completion date of 4/13/2026). On 04/29/2026 at 10:37 AM, review of Resident #58's medical record revealed the MDS completed on 4/13/26 was transmitted late (more than 14 days after the completion date of 4/13/2026). On 04/30/2026 at 8:03 AM, review of the MDS Final Validation Report which shows when the MDS was transmitted confirmed that Resident #47 and #58's recent MDS assessments noted above were transmitted late. On 04/30/2026 at 8:27 AM, an interview with the Regional Director for Reimbursement confirmed the findings noted above that the MDS assessments were transmitted late. On 05/01/2026 at 1:23 PM, the surveyor reviewed the concern with the Nursing Home Administrator during the survey exit conference.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, Resident and staff interviews and surveyor record reviews it was determined that the facility failed to code Minimum Data Set (MDS) Assessments accurately for Residents. This finding was found to be evident in 2 (Resident #13 and #23) out of 2 Residents reviewed for falls and continence. The findings include:The Minimum Data Set (MDS) is a federally mandated, standardized clinical assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a Resident's functional, medical, psychosocial, and cognitive status, including skin and health conditions, nutrition, continence, medications, treatments, and active diagnoses. It drives care planning, quality monitoring, and reimbursement, with assessments required upon admission, quarterly, annually, discharge and significant changes in status of Residents. The assessment is completed by licensed health care professionals employed by the nursing home, such as a Registered Nurse (RN). The information is transmitted electronically to the Centers of Medicare and Medicaid Services (CMS). The purpose of the MDS is to ensure accurate, comprehensive assessments to improve Resident care and identify health problems. The data helps form the basis for individual Resident care plans. A Care Plan is a formalized, dynamic document outlining a Resident's health conditions, goals, and specific interventions, created collaboratively by healthcare professionals, patients, and families. The care plan ensures personalized care, tracks progress, and includes medication, treatment plans, and provider information to improve health outcomes and safety, especially for chronic conditions. The key components of a care plan include assessment (identification of Resident needs, symptoms, and medical history), nursing diagnosis (identification of specific patient health problems), goals/desired outcomes (actionable, measurable, and patient-centered targets), interventions (specific, planned actions to be taken by the interdisciplinary care team), and evaluation (regular review of the plan's effectiveness, adjusting as needed). The care plan streamlines care delivery and helps manage long-term needs.A colostomy is a surgical procedure that creates an opening (stoma) in the abdominal wall, bringing a portion of the colon through to allow waste to pass into a pouch, typically for treating bowel cancers, obstructions, or injuries. The colostomy can be temporary or permanent and allows for a normal lifestyle.The surveyor observed Resident #23 on 4/29/2026 at 10:30 AM in bed, in no distress, alert and oriented to person. Resident stated that he/she was doing okay and that the colostomy bag was not leaking.The surveyor conducted a record review of Resident #23's medical record on 4/29/2026 at 1:15 PM. Record review revealed that Resident #23 had a physician order for colostomy care and a comprehensive care plan that addressed the Resident's colostomy care. Further review of the medical record revealed that the admission Medicare 5-Day MDS assessment dated [DATE] was coded that Resident #23 had a colostomy, however, bowel continence was coded always incontinent.At 3:35 PM on 4/29/2026 the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were notified that Resident #23's admission Medicare 5-Day MDS assessment was coded inaccurately for bowel continence because the Resident had a colostomy, but the MDS assessment was coded always incontinent instead of Not rated. The LNHA and the DON acknowledged the surveyor and stated that they would follow up with the MDS Coordinator.In a follow up record review on 4/30/32026 at 7:10 AM of Resident #23's admission Medicare 5-Day MDS assessment dated [DATE], the review revealed that there was a correction/modification to the MDS on 4/29/2026 at 4:16 PM by the MDS Coordinator. Bowel continence was coded Not rated on the Modification of admission Medicare 5-Day MDS assessment.In an interview with the RN MDS Coordinator #18 on 4/30/2026 at 8:30 AM the surveyor asked what the expectation was for coding bowel continence for Residents with a colostomy on the MDS assessment. RN MDS Coordinator #18 stated that bowel continence should be coded Not rated on the MDS assessments when Residents had a colostomy. The surveyor conveyed that Resident #23 was coded for a colostomy on the admission Medicare 5-Day MDS assessment dated [DATE], however, bowel continence was coded as (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	always incontinent. RN MDS Coordinator #18 stated that this was not accurate coding, and a modification/correction was made to the admission Medicare 5-Day MDS assessment that indicated bowel continence as Not rated.A record review was conducted by the surveyor on 4/30/2026 at 3:45 PM for Resident #13's medical record. Review of the medical record revealed that Resident #13 had a fall on 2/19/2026 with left thigh pain and sustained a fracture of the left femur as indicated on the Resident's hospital discharge summary. Further review of the discharge summary revealed that the Resident had surgical repair of the left femur fracture, intramedullary nailing and fixation of the left femur fracture. Review of the Discharge MDS assessment dated [DATE] was coded that Resident had 2 or more falls without injury. Additionally, review of the Quarterly MDS assessment dated [DATE] revealed that the orthopedic surgery (intramedullary nailing and fixation) for repair of the left femur fracture was not coded on the MDS.In an interview with the RN MDS Coordinator #18 at 8:45 AM on 5/1/2026 the surveyor asked what the expectation was for coding MDS assessments for a fall with a fracture and a surgical procedure. RN MDS Coordinator #18 stated that the MDS assessment should be coded as a fall with major injury if a Resident falls and sustained a fracture and the surgical procedure should be coded on the MDS assessment if the surgical procedure occurred within 30 days. The surveyor conveyed that Resident #13 had a fall with fracture on 2/19/2026 and a surgical procedure to repair the fracture on 2/20/2026, and the Discharge MDS dated [DATE] was not coded for the fall with fracture, and the Quarterly MDS dated [DATE] was not coded for the surgical procedure. The RN MDS Coordinator #18 acknowledged the surveyor and stated that she would make the necessary corrections / modifications to these MDS assessments. Follow up record review at 12:15 PM 5/1/2026 of Resident #13's MDS assessments revealed that the Modification of 2/19/2026 Discharge MDS was coded for a fall with major injury (fracture), and the Modification of 3/16/2026 Quarterly MDS was coded for the surgical procedure (repair fracture of leg).Nephrostomy tube is a thin, flexible catheter inserted through the skin of the back into the kidney to drain urine directly into an external bag, bypassing blockages caused by tumors, stones, or infections. This ultrasound-guided procedure that takes approximately 30-90 is usually temporary but requires daily care (cleaning and flushing) and brings risks of infection or blockage, often every three months.Further record review on 5/1/2026 of Resident #13's Quarterly MDS assessment dated [DATE] revealed that it was coded that Resident had an indwelling catheter (nephrostomy tube), however, Resident did not have an indwelling catheter (nephrostomy tube) at that time because the indwelling catheter (nephrostomy tube) was removed on 2/4/2026. This removal of the nephrostomy tube was documented at 22:39 on 2/4/2026 in a nurse's progress note.In a follow up interview with the RN MDS Coordinator #18 on 5/1/2026 at 11:20 AM the surveyor conveyed that Resident #13's Quarterly MDS dated [DATE] was coded that Resident had an indwelling catheter (nephrostomy tube), however, the indwelling catheter (nephrostomy tube) was removed on 2/4/2026. RN MDS Coordinator #18 stated that she would review the notes as she was not sure of the status of the nephrostomy tube. The Director of Nursing (DON) was notified of the concerns with the inaccurate coding on the MDS assessments for Resident #13 at 11:30 AM on 5/1/2026.In an interview with the RN Unit Manager #21 at 11:45 AM on 5/1/2026 she stated that Resident #13 had a nephrotomy tube for a short time period, but it was removed. RN Unit Manager #21 provided the surveyor with progress notes from Resident #13's medical record, one progress note dated 12/4/2025 which indicated that the nephrostomy tube was inserted and the other progress note dated 2/4/2026 which indicated that the nephrostomy tube was removed. RN Unit Manager #21 confirmed that Resident #13's nephrostomy tube was removed on 2/4/2026.No additional information was provided by the facility at the time of survey exit.

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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. Based on observation, staff interviews and surveyor record reviews it was determined that the facility failed to develop/implement a comprehensive care plan for a Resident. This finding was found to be evident in 1 (Resident #13) out of 4 Residents reviewed for care plans.The findings include:A Care Plan is a formalized, dynamic document outlining a Resident's health conditions, goals, and specific interventions, created collaboratively by healthcare professionals, patients, and families. The care plan ensures personalized care, tracks progress, and includes medication, treatment plans, and provider information to improve health outcomes and safety, especially for chronic conditions. The key components of a care plan include assessment (identification of Resident needs, symptoms, and medical history), nursing diagnosis (identification of specific patient health problems), goals/desired outcomes (actionable, measurable, and patient-centered targets), interventions (specific, planned actions to be taken by the interdisciplinary care team), and evaluation (regular review of the plan's effectiveness, adjusting as needed). The care plan streamlines care delivery and helps manage long-term needs.On 4/29/2026 at 11:00 AM, the surveyor observed Resident #13 alert, well-groomed, in no distress sitting in a wheelchair in the hall near the nursing station.The surveyor conducted a record review of Resident #13's medical record on 4/30/2026 at 3:45 PM. Review of the medical record revealed that Resident had a fall with left thigh pain at the facility on 2/19/2026, transferred to the hospital on 2/19/2026, and the x-ray done in the emergency room showed left intertrochanteric femur fracture. Additionally, the Resident had surgical intervention on 2/20/2026 for intramedullary nail and fixation of left intertrochanteric femur fracture. Resident #13 returned to the facility on 2/23/2026 from the hospital. Further review of the medical record on 4/30/2026 revealed that there was not a comprehensive care plan for Resident #13 for the left femur fracture and the operative procedure for the intramedullary nail and fixation of the left femur fracture.In an interview with employee #18 at 8:45 AM on 5/1/2026 the surveyor asked who was responsible for the care plan process. Employee #18 indicated that the interdisciplinary clinical team (IDT) was responsible for the care plan process. The surveyor conveyed to employee #18 that Resident #13 did not have a comprehensive care plan for the diagnosis of left femur fracture, and the operative procedure for nailing and fixation of the left femur fracture. Employee #18 acknowledged the surveyor and stated that she would follow up with nursing. Nephrostomy tube is a thin, flexible catheter inserted through the skin of the back into the kidney to drain urine directly into an external bag, bypassing blockages caused by tumors, stones, or infections. The 30-90-minute, ultrasound-guided procedure is usually temporary but requires daily care (cleaning and flushing) and brings risks of infection or blockage, often every three months.Further review of Resident #13's medical record on 5/1/2026, specifically the progress note revealed that Resident had a nephrostomy tube on 12/4/2025 at 17:47 when he/she was readmitted to the facility, and on 2/4/2026 at 22:39 the Resident had a surgical procedure to remove the nephrostomy tube. Review of the comprehensive care plan with revisions did not reveal that Resident #13 had a care plan for a nephrostomy tube or care of the nephrostomy tube during that time.In a follow up interview with employee #18 at 11:20 AM on 5/1/2026 the surveyor conveyed that Resident #13's comprehensive care plan with revisions did not reveal that Resident had a care plan for the nephrostomy tube and the care of the nephrostomy tube. Employee #18 acknowledged the surveyor and stated that she would review the notes as she was not sure of the status of the nephrostomy tube.At 11:30 AM on 5/1/2026 the surveyor conveyed to the Director of Nursing (DON) that review of Resident #13's comprehensive care plan with revisions did not reveal that Resident had a care plan for the left femur fracture and the surgical repair of the left femur fracture, and the nephrostomy tube and care of the nephrostomy tube. DON acknowledged the surveyor and stated that she would review and follow up. At 11:45 AM on 5/1/2026 in an interview with Registered Nurse (RN) Unit Manager #21 the surveyor asked if Resident #13 had a nephrostomy tube, and she stated no, the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nephrostomy tube was removed earlier this year. RN Unit Manager #21 provided the documentation regarding the nephrotomy tube from Resident #13's medical record.No additional information was provided by the facility at the time of survey exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that the facility staff failed to ensure resident medical records were accurately documented and maintained according to professional standard of practice. This was evident for 3 (Resident #3 #78 and #13) of 7 residents reviewed for advance directives and medical records accuracy. The findings include: 1.On 04/28/2026 at 7:55 AM, review of Resident #3's medical record revealed a document titled, Social Services Assessment and Documentation, dated 3/20/2025 signed by Director of Social Services #3 that indicated on line 5b. that the resident did not have an advanced directive, on line 5c. that additional conversation regarding advanced care planning was not provided, 5d. that the opportunity to complete an advanced directive was not provided, and 5e. that advanced directive educational materials were not provided to the resident. On 04/28/2026 at 8:14 AM, review of Resident #78's medical record revealed a document titled, Social Services Assessment and Documentation, dated 3/02/2026 signed by Director of Social Services #3 that indicated on line 5b. that the resident did not have an advanced directive, on line 5c. that additional conversation regarding advanced care planning was not provided, 5d. that the opportunity to complete an advanced directive was not provided, and 5e. that advanced directive educational materials were not provided to the resident. On 04/28/2026 at 9:55 AM, an interview with Director of Social Services #3 revealed that all residents were asked about advanced directives and if they did not have one they would be offered materials to formulate one. She further indicated they document it on the, social services assessment, document noted above. On 04/28/2026 at 1:09 PM, the surveyor reviewed the concern with the Nursing Home Administrator and requested any further documentation that would indicate information to formulate an advanced directives were offered to Resident #3 and #78 when they indicated they did not have one. On 04/28/2026 at 1:25 PM, a follow up interview with the Director of Social Services #3 revealed that she felt the template was confusing the way it is read. She further indicated it can be interpreted several different ways when she would document. The surveyor reviewed the concern with #3 along with the Nursing Home Administrator who was also present during the interview. 2. Anticoagulant drugs, commonly known as blood thinners, are medications that prevent harmful blood clots from forming or growing by inhibiting clotting factors in the blood. This medication is used to treat or prevent conditions like stroke, deep vein thrombosis (DVT), and pulmonary embolism (PE). Common types include Apixaban (Eliquis), Rivaroxaban (Xarelto), and Warfarin (Coumadin). Excessive bleeding is the primary side effect of anticoagulant medications. Antiplatelet drugs are medications that prevent blood clots by reducing platelet aggregation (sticking together in the arteries). These medications are crucial for reducing risks of heart attacks, strokes, and cardiovascular events. Common types include Aspirin, Clopidogrel (Plavix), Ticagrelor (Brilinta), and Cilostazol (Pletaal). Key side effects include increased bleeding risk, bruising, and stomach upset. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The difference between these 2 medications is antiplatelets keep platelets from clumping, generally preventing clots in the arteries, and anticoagulants (blood thinners) work on different clotting factors to prevent clots in the veins and heart. The surveyor conducted a record review of Resident #13's medical record on 4/30/2026 at 4:10 PM. Review of the medical record revealed that Resident had an active physician order dated 4/1/2026 for Anticoagulant/Antiplatelet Medication – Monitor for discolored urine, black tarry stools, sudden severe headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds; Document: Y (Yes) if monitored and none of the above observed; N (No) if monitored and any of the above was observed, select chart code: Other/See Nurses Notes and progress notes findings every shift. Further review of the physician orders for Resident #13 revealed that Resident did not have an active physician order for an anticoagulant medication or antiplatelet medication. A Care Plan is a formalized, dynamic document outlining a Resident's health conditions, goals, and specific interventions, created collaboratively by healthcare professionals, patients, and families. The care plan ensures personalized care, tracks progress, and includes medication, treatment plans, and provider information to improve health outcomes and safety, especially for chronic conditions. The key components of a care plan include assessment (identification of Resident needs, symptoms, and medical history), nursing diagnosis (identification of specific patient health problems), goals/desired outcomes (actionable, measurable, and patient-centered targets), interventions (specific, planned actions to be taken by the interdisciplinary care team), and evaluation (regular review of the plan's effectiveness, adjusting as needed). The care plan streamlines care delivery and helps manage long-term needs. Continued review of Resident #13's medical record on 4/30/2026 revealed that the care plan had a goal that indicated The Resident will remain free of complications related to anticoagulant therapy through review date with an initiation date of 4/21/2026 and a target date of 5/31/2026. Additionally, there were interventions on the care plan that indicated Give medications as ordered, monitor/document for side effects and effectiveness, monitor/document/report PRN any signs/symptoms of complications abnormal bleeding, bruising, petechiae related to anticoagulant use. In an interview with employee #18 at 8:45 AM on 5/1/2026 the surveyor asked who was responsible for the care plan process. Employee #18 indicated that the interdisciplinary clinical team (IDT) was responsible for the care plan process. At 11:30 AM on 5/1/2026 the surveyor conveyed to the Director of Nursing (DON) that review of Resident #13's medical record revealed that Resident was not currently receiving an antiplatelet or anticoagulant medication, but review of the active physician orders and the care plan indicated that Resident #13 was being monitored for side effects and complications related to antiplatelet and anticoagulant medication usage. DON acknowledged the surveyor and stated that she would review and follow up. No additional information was provided by the facility at the time of survey exit.