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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure a safe, clean, and comfortable homelike environment for the residents. This was evident for multiple areas within the facility observed during the annual survey. The findings include: 1.On 04/27/2026 at 07:31 AM, an observation of the dining room revealed the wall across from the door to the basement stairs by the kitchen door, which had a hole in the wall that was approximately 4 inches long and 2 inches wide. On 04/27/2026 at 7:52 AM, an observation of the left bottom corner wall outside of room [ROOM NUMBER]-CD when looking into the room revealed a piece of the dry wall which was missing, a portion of the wall that exposed through a cracked, and the footboard which was detached from the wall at the end. On 04/27/2026 at 7:53 AM, an observation of the hallway wall outside of room [ROOM NUMBER] which had a large horizontal hole in the wall which was approximately 36 inches long and 2 inches wide. On 04/27/2026 at 7:58 AM, an observation of room [ROOM NUMBER] revealed the outside of the bathroom door has a horizontal indent that was approximately 6 inches long and an inch wide Further observation of room [ROOM NUMBER] revealed the wall to the right of the B bed when looking at the bed, which had an indent in the wall and exposed the inside of the wall. The indent as a whole was approximately 4 inches long and 12 inches wide. Further observation of room [ROOM NUMBER] revealed the foot board of the B bed was completely detached from the bed and was leaning on the steel frame of the bed. On 04/27/2026 at 8:06 AM, an observation of room [ROOM NUMBER] revealed 3 separate areas of the window blinds which were broken off. On 04/27/2026 at 9:19 AM, an observation of room [ROOM NUMBER] revealed the television wall mount had been moved from where it previously was on the wall, which exposed 5 various sizes of holes in the wall from approximately 2 centimeters by 2 centimeters to approximately 2 inches by 2 inches. One of the holes on the wall had a black wire coming out of it connecting to where the new television mount was. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/27/2026 at 11:15 AM, an observation on room [ROOM NUMBER] revealed the heating, ventilation, and air conditioning unit (HVAC) which had a square size area about 5 inches by 5 inches, without a cover, leaving the inside parts of the unit exposed. On 04/27/2026 at 11:39 AM, an observation of the unit hallways revealed room [ROOM NUMBER], 116, 119, and 121 had a room number plaque which the room numbers were written in with sharpie and/or cracked. On 04/27/2026 at 11:56 AM, an observation of room [ROOM NUMBER] revealed a nightstand dresser across from the A bed which was missing the drawer. Further observation of room [ROOM NUMBER] revealed the call bell wall outlet, which failed to have an electrical outlet cover on it. On 04/29/2026 at 8:59 AM, an interview with the Maintenance Director (Staff #22) revealed that he was informed of maintenance concerns through an online system. He further said the facility was in the process of fixing a lot of maintenance concerns since he started in March 2026. On 04/29/2026 at 9:13 AM, the surveyor walked around with Staff #22 to review the identified concerns noted above. The surveyor reviewed the concern. 2. On 4/27/26 at 9:13 AM during the initial rounds on the floor, the surveyor observed in room [ROOM NUMBER]- a hole in the wall behind the entrance door measuring about 5x6 inches, it looked like it was punched in. In room [ROOM NUMBER] bathroom, the toilet seat was scrapped off in three different spots exposing the brown wood underneath and around the edges measuring about 7 x 0.5 inches, 3 x 2 inches and 4 x 0.25 inches respectively. On 4/27/26 at 9:33 AM in room [ROOM NUMBER]B, Resident #88's nightstand was observed missing on the front, a brown piece of wood in the 2nd drawer from the top. At the foot of the bed, the corner of the baseboard was broken off, and a large white spot was also visible at the base of the wall. The resident's bed was up against the wall and the white paint by the window ceil next to the bed was chipped off about 12 inches long exposing the wood. The surveyor also observed on 4/27/2026 at 11:06 AM in room [ROOM NUMBER]B, that Resident #54 had a wheelchair by their bed. The Wheelchair seat was torn exposing white particles underneath including the arm rest and back rest area measuring about 4x16 inches. Resident #54 also stated that the phone on their nightstand can't receive calls but can dial out. The surveyor further observed that the foot board on Resident #54's bed was ripped off about 7x4 inches exposing the sharp edges. In an Interview with the maintenance director #22 on 4/29/2026 at 8:55 AM, he was asked how often he rounds on the units, and he said daily but have a weekly and monthly scheduled checks. He explained that the staff use a system called TELS to place work orders for him on the units or to notify him of what needs to be fixed. He was asked if he does regular room checks and he said they don't but have a section-by-section plan room checks. The maintenance director was made aware that some of the residents' beds are in terrible condition, and he said some of the beds are old and mechanical and he is in the process of checking and removing all the old equipment, repainting rooms, and touching up on the buildings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/2026 at 9:25 AM The surveyor did a walk around with the maintenance director and the administrator. The surveyor made them visually aware of all the environmental concerns; they agreed that it was a concern and said they would take care of it.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on medical record review and staff interview, it was determined the facility staff failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days after the assessment reference date. This was evident for 6 (Resident #22, # 41, #80, #47, #58, and #69) of 7 residents reviewed during the annual survey. The findings include: 1, The Minimum Data Set (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 these individualized needs, and that the care is provided as planned to meet the needs of each resident. The MDS is to be completed 14 days after the assessment reference date (ARD). On 4/28/2026 at 9:35AM medical record review of the MDS assessment revealed that Resident #22 the MDS completion date of 4/13/2026 was late. Resident # 41 the MDS completion date of 4/13/2026 was late. Resident #80 the MDS completion date of 4/13/2026 was late. 04/30/2026 8:27 AM Staff #18, the Regional Director of Reimbursement, MDS was Interviewed and confirmed the above quarterly assessments are overdue and were not completed 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 late (more than 14 days after the ARD of 3/26/2026). On 04/29/2026 at 10:37 AM, review of Resident #58's medical record revealed the MDS completed date on 4/13/26 was late (more than 14 days after the ARD of 3/21/2026). On 04/29/2026 at 10:46 AM, review of Resident #69's medical record revealed the MDS completed on 4/14/26 was late (more than 14 days after the ARD of 3/29/2026). 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 completed late. On 05/01/2026 at 1:23 PM, the surveyor reviewed the concern with the Nursing Home Administrator during the survey exit conference.

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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.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interview, it was determined that the facility failed to ensure residents were served meals according to their meal ticket. This was evident for 11 (Resident #14, #19, #30, #39, #41, #51, #58, #66, #70, #87, and #92) of 83 trays observed during the lunch meal tray lineThe findings include:On 04/29/2026 at 11:35 AM, an observation of the kitchen lunch tray line revealed [NAME] (Staff #15) started to plate the food. On 04/29/2026 at 12:07 PM, Resident #19's meal ticket was placed on the tray and [NAME] (Staff #16) noted that it indicated the resident was supposed to receive garlic egg noodles as the main food item for the meal. [NAME] (Staff #15) indicated they did not have any garlic egg noodles. Staff #15 gave Resident #19 the regular main for the meal that was on the menu which was turkey.On 04/29/2026 at 12:24 PM, Staff #15 indicated they had finished the unit trays and would start on the dining room trays for those who are eating in the dining room. On 04/29/2026 at 12:33 PM, a follow up observation of the kitchen revealed they ran out of the squash medley vegetable side that was on the menu and meal tickets and were using broccoli as an alternative.On 04/29/2026 at 12:34 PM, an interview with Staff #15 revealed that there were 10 residents (Resident #14, #30, #39, #41, #51, #58, #66, #70, #87, and #92) eating in the dining room who would be receiving broccoli, even though their meal tickets indicated squash medley as the vegetable side.On 04/29/2026 at 1:21 PM, an interview with Food Services Director (Staff #17) revealed that he or the assigned cook reviewed the meal tickets prior to each meal to ensure that any special food requests could be prepared and so that they have enough food that was on the menu for each resident. The surveyor reviewed the concern of the findings identified during the lunch tray line observation with Staff #17 and the Nursing Home Administrator who was present during the interview.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Number of residents sampled: Number of residents cited: Based on observation and interview, it was determined that the facility failed to maintain residents dignity by staff knocking prior to entering their rooms. This was evident for 3 (Resident #48, #67, #73) of 24 residents screened during the initial pool process of the annual survey.The findings include:1) On 04/27/2026 at 9:03 AM, during the initial interview with Resident #73, Geriatric Nursing Assistant (Staff #20) entered the room when the door was closed, without knocking. As Staff #20 noticed the surveyor, she proceeded to say, knock knock knock, after she had already opened the door and walked into the room.On 04/27/2026 at 9:04 AM, further interview with Resident #73 revealed that some of the staff do not knock prior to walking into the room. 2) On 04/27/2026 at 11:59 AM, during the initial interview with Resident #68, Geriatric Nursing Assistant (Staff #4) opened the door and entered the room without knocking. As Staff #4 noticed the surveyor, she proceeded to knock on the side of the door where the handle was, after she had already opened the door and walked into the room.3) On 04/27/2026 at 12:09 PM, during the initial interview with Resident #47, Geriatric Nursing Assistant (Staff #19) opened the door and entered the room without knocking. At the same time, an interview with Staff #19 revealed that she thought both residents were out of the room. On 04/30/2026 at 10:18 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood.

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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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Complete Care at Springbrook	12325 New Hampshire Avenue Silver Spring, MD 20904

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, and record review, it was determined that the facility failed to provide residents who are unable to carry out activities of daily living (ADLs) the necessary services to maintain personal hygiene. This was evident for 2 (Resident #54 and #109) of 3 residents reviewed for ADLs during the annual survey, 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, psychological, and cognitive status.1.On 4/27/2026 at 11:17 AM Resident #54 stated that a Geriatric Nursing Assistant #23(GNA) puts double diapers on them at night and did so again last night 4/25/27. That GNA #23 worked a double shift, 3-11 and 11-7 shift that night. The resident stated that s/he was developing redness on their peri area and bottom because of the double diapering.A review of resident #54's care plan with initiation dated of 3/13/26 and 3/24/26 respectively, documented that resident has an ADL self-care performance deficit related to (r/t) Impaired balance and has potential for impairment to skin integrity r/t incontinence, fall risk, decreased mobility. Some Interventions were to Keep the skin clean and dry.2. On 4/27/2026 at 12:12 PM Resident #109 also told the surveyor that Staff has been putting two diapers on them because s/he was on diuretics, a medication that removes excess water through increase urination. A review of the admission Minimum Data Set (MDS) with assessment reference date (ARD) of 4/22/26 section GG-Functional ability documented that resident was dependent on staff with personal hygiene and transfers. Further review of the physicians orders also revealed an order dated 4/15/26, it reads: Lasix Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day. In a phone Interview with GNA #23 on 4/28/2026 at 1:58 PM she was asked how often she changes the residents' diapers on her shift, and she said every 2 hours and as needed. She was asked how she identify those who needed to be changed and she said they would put their call lights on, and for the cognitively impaired residents, she would check them. She was asked what could happen if residents are not changed frequently. She stated that they can get redness down there and/or urinary tract infection (UTI). She was asked how many diapers are put on her residents when she changed them and she said one. She was asked if she ever put two diapers on her residents and she said she has not used two. She was made aware that some residents mentioned her name that she uses double diaper on them and asked to explain. She said she cuts out the pull ups and used them like a pad on the residents. On 4/28/2026 at 2:32 PM in an Interview with the Director of Nursing (DON), she was asked about their policy regarding double diapering. She said staff should not be double diapering at all because it's not allowed. She was made aware of the above concerns, and she said it's unacceptable and is a no-no. She indicated that the staff will be suspended and an in-service provided to all nursing staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of medical records and interview with staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Residents #88) of 5 residents reviewed during the annual survey. The findings include:On 04/30/2026 at 8:22 AM: A review of Resident #88's medical record showed that the Medication Regimen Review (MMR) for December 3, 2025, lacked documentation of a review being conducted.The pharmacy had recommended that the Multivitamin be given 4 hours after the Levothyroxine was administered. The recommendation was Please Administer Multivitamin at least 4 hours after the Levothyroxine.A review of the Medication Administration Record (MAR) for April 2026 revealed that Resident #88's Levothyroxine continued to be administered at 6 AM and the Multivitamin at 9 AM, which is only 3 hours apart instead of the recommended 4 hours apart.04/30/2026 at 9:58 AM: Staff #14, the Regional Clinical Nurse, was interviewed and stated they would check on whether Resident #88's December 3, 2025, MRR was addressed.Staff #14 later verified that the pharmacy recommendation regarding Levothyroxine and Multivitamin was not addressed, and the MAR for April 2026 still reflected the times of 6 AM for Levothyroxine and 9 AM for the Multivitamin.Staff #14 verbalized understanding that failing to follow up on the pharmacy recommendation in a timely manner was an issue and confirmed that pharmacy reviews are generally completed monthly.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observations, staff interviews and surveyor record reviews it was determined that the facility failed to ensure that physician medication orders had 1) appropriate indication for usage of the medications and 2) appropriate monitoring and documenting for side effects of medications for a Resident. This finding was found to be evident in 1 (Resident #111) out of 3 Residents reviewed for physician medication orders.The findings include:The surveyor conducted an observation of medication administration on 4/29/2026 at 7:49 AM with Licensed Practical Nurse (LPN) #10 for Resident #111.Apixaban (Eliquis) is an anticoagulant medication, blood thinner.Furosemide (Lasix) is a diuretic medication, water pill.At 10:45 AM on 4/29/2026 the surveyor conducted a record review of Resident #111's medical record. Review of the medical record revealed that Resident had physician medication orders for Apixaban (Eliquis) 2.5 mg by mouth two times a day, and Lasix (Furosemide) 40 mg by mouth one time a day for pleural effusions. The Eliquis order did not have an indication for usage of the medication included in the physician order, and there was not a physician order for monitoring and documenting the side effects for the usage of Lasix.Diltiazem, Hydralazine and Losartan are medications prescribed for hypertension (high blood pressure).Ezetimibe is a medication prescribed for hypercholesterolemia (high cholesterol level in the blood).Tamsulosin is a medication prescribed for benign prostatic hyperplasia (BPH), enlarged prostate.Further review of the medical record on 4/29/2026 for Resident #111 revealed that additional medications did not have indication for usage in the physician orders. These medications were Diltiazem 360 mg 1 capsule by mouth in the evening, Ezetimibe 10 mg 1 tablet by mouth one time a day, Hydralazine 50 mg 1 tablet every 8 hours, Losartan 25 mg 1 tablet by mouth one time a day, and Tamsulosin 0.4 mg 1 capsule by mouth at bedtime. In an interview with Registered Nurse (RN) Unit Manager (UM) #13 at 1:20 PM on 4/29/2026 the surveyor asked what the expectation was for what was included in a physician medication order for a Resident. RN UM #13 stated that the physician medication order should include the medication, dosage, route, frequency, and the indication for the medication. The surveyor reviewed with the RN UM the medication orders for Eliquis, Diltiazem, Ezetimibe, Hydralazine, Losartan, and Tamsulosin for Resident #111 that did not have the indication for usage. The RN UM #13 acknowledged the surveyor and stated that she would follow up. At 11:30 AM on 5/1/2026 the surveyor conveyed to the Director of Nursing (DON) that review of Resident #111's medical record revealed that Resident did not have indications for usage of several medications included in the physician orders. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility failed to ensure food was stored to maintain food safety. This was evident during the initial observation of the kitchen upon survey entry.The findings include:1) On 04/27/2026 at 7:34 AM, an initial observation of the kitchen revealed in the freezer there were french toast sticks, green beans, and chicken patties which were all opened and unlabeled.At the same time, further observation of the kitchen fridge next to the freezer revealed turkey bacon which was opened and unlabeled.On 04/27/2026 and 7:46 AM, further observation of the kitchen on a top shelf above a preparation table revealed a box of, quick creamy wheat, which was opened and unlabeled, plastic square containers with lids of what looked to be oatmeal and creamy wheat, which were opened and unlabeled, all purpose flour opened and unlabeled, and a large jug of, salsa picante, which was opened and unlabeled with the date it was opened. At the same time, further observation of the kitchen fridge with salad dressings had a plastic container with a lid full of an orange substance, but had no label of what it was or the date it was prepared. There was a head of iceberg lettuce that was in a large bag that at one time had approximately 6-8 heads of lettuce, which was opened and unlabeled.On 04/27/2026 at 7:48 AM, an interview with [NAME] (Staff #15) revealed that anytime anything is opened for the first time, the expectation of staff was that it would be labeled with the name of the item and date it was opened, whether it was kept in the same container/bag or put in another container. On 04/27/2026 at 7:53 AM, an observation of the downstairs dry storage room revealed a large opened box lined with a blue bag that had raisins which opened to the air and unlabeled with the date. At the same time, further observation of the dry storage room revealed an opened loaf of rye bread that indicated it was best by March 27th. On 04/27/2026 at 9:38 AM, the surveyor walked around the kitchen with Staff #17 to review the identified opened, unlabeled, and nondated items that were identified during the initial observation. As all of the opened and unlabeled items noted above were shown to Staff #17, he proceeded to label them with the date of 4/27/26. 2) On 04/27/2026 at 7:50 AM, an initial observation of the downstairs dry storage room revealed approximately 15 boxes of various items, frozen items, fruits, and meats that were stacked on the floor. The boxes were all labeled with keep refrigerated, and/or keep frozen. At the same time, Staff #15 was present during the observation. An interview with Staff #15 revealed that the truck had dropped off the items not too long ago and that the Food Services Director (Staff #17) would arrive shortly to put all of the items in their prospective places. On 04/27/2026 at 8:02 AM, the surveyor left the basement dry storage room where the freezer and fridge items were stacked in the room. On 04/27/2026 at 8:18 AM, further observation of the basement dry storage room revealed the freezer and fridge items were still stacked, and Food Services Director (Staff #17) was starting to label the items while stacked with the date. At the same time, an interview with Staff #17 revealed that he normally puts the items away in their prospective places on days when the food service truck delivers the items. On 4/29/2026 at 1:19 PM, an interview with the Food Services Director (Staff #17) revealed that the items delivered by the truck came earlier than normal on 4/27/2026. The surveyor asked if they have a process in place for the items to be put away if delivered early and he was unable to indicate a process that was in place. On 04/29/2026 at 1:20 PM, the surveyor reviewed the concerns with the Nursing Home Administrator and Staff #17.

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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 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.