STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215145	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hyattsville	4922 Lasalle Road Hyattsville, MD 20782

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and staff interview, the facility failed to ensure a resident received care and services in accordance with physician orders and the resident's care plan to prevent pressure injuries. Specifically, the facility failed to reposition a resident every two hours as ordered and care planned. This failure occurred during multiple observations and placed one (1) of one (1) resident at risk for increased pressure injury development who were reviewed for turning and positioning. During an observation on 1/7/26 at 10:04 am, the surveyor observed Resident #8 lying in bed on the right side at an angle facing the wall.During another observation on 1/7/26 at 4:54 pm, the surveyor observed the resident lying supine (lying on back facing upward) with a wedge at their feet.During an observation on 1/8/26 at 9:38 am of Resident #8 the surveyor again observed the resident in the same position supine with no wedge, with no evidence the resident had been turned or repositioned. No staff were observed providing repositioning assistance during this time period.During an observation on 1/8/26 at 12:50 pm, the surveyor observed Resident #8 in bed positioned on their back with no wedge.During an observation at 3:16 pm, the surveyor again observed the resident in the same position, indicating the resident had not been repositioned in accordance with physician orders and the care plan.Record review of Resident #8 revealed an admission date of 8/16/25 with a list of diagnoses that included Pressure Ulcer of Sacral Region, Stage 4, Unspecified Dementia, Severe, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarction without Residual Deficits.Review of Resident #8's Care Plan with a date initiated of 9/8/2025 and a revision date of 10/2/2025, confirmed that Resident #8 had pressure injury preventative interventions that included being turned and repositioned every two (2) hours.Review of Resident #8's Physician's Orders with an order date of 8/16/2025, revealed an order to assist and/or encourage resident to turn and position every 2 hours for pressure relief every shift.During an interview on 1/8/26 at 11:46 am Licensed Practical Nurse (LPN 12) stated that for positioning staff went by the facility protocol, which was to reposition resident every two hours. During an interview on 1/8/26 at 12:04 pm LPN 13 reported that they round every two hours. LPN 13 also revealed that there was a time clock that they use to know what position and what time to reposition the resident and it was kept on every badge.During an interview on 1/8/26 at 12:16 pm LPN 14 stated that if the patient was stable, that they would reposition residents every 2 hours. LPN 14 acknowledged the clock that was on the back of every badge and that the nurses and the geriatric nursing assistants (GNA) work together.During an interview on 1/8/26 at 12:52 pm with the Assistant Director of Nursing (ADON) stated that the facility provided the staff a clock. Staff were not supposed to just walk through the hallway, and that training was on-going, and residents that are not able to move themselves, are supposed to be turned. The expectation was to turn the resident every two hours. The two GNAs on the floor knew that they were supposed to turn Resident #8. The only way to know if they had been turned, would be done by seeing the resident and making their rounds, it was an (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on-going education, and that the nurse's needed to over-see that the GNAs were doing it.During an interview on 1/9/26 at 8:54 am GNA 10 stated that they were supposed to round every 2 hours.During an interview on 1/9/26 at 9:08 am GNA 11 reported that they did rounds at the beginning of their shift. They stated that they tried to round every 2 hours or once an hour. GNA 11 also said that they knew it was required to do their rounds twice an hour.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and review of infection prevention practices, the facility failed to implement proper infection control measures to prevent contamination of tracheostomy equipment. Specifically, the facility failed to ensure tracheostomy tubing remained off the floor for three (3) of four (4) residents observed for tracheostomy equipment. This failure occurred on two separate days and placed residents at risk for infection.1.) During an observation on 1/6/2026 at 10:15 am resident #14 who had a tracheostomy, with tracheostomy tubing extending from the tracheostomy site and resting on the floor. No staff were observed intervening to reposition or replace the tubing at that time.Record review of Resident #14 revealed, an admission date of 1/6/2026, an admission date of 5/10/2022, an original admission date of 7/10/2020.During an observation on 1/7/2026 at 9:54 am resident #14 was seen in their electric wheelchair in the resident's room with the tracheostomy tubing touching the floor.2.) During an observation on 1/6/2026 at 10:21 am resident # 6, who had a tracheostomy, with tracheostomy tubing touching the floor while connected to the resident's airway.Record review of Resident #6 revealed, an admission date of 10/7/2025, and a diagnoses list that included traumatic hemorrhage of left cerebrum with loss of consciousness status unknown, sequela, encounter for attention to tracheostomy, functional quadriplegia.3.) During an observation on 1/7/2026 at 8:40 am resident #10, who had a tracheostomy, with tracheostomy tubing in contact with the floor during routine care.Record review of Resident #10 revealed, an admission date of 12/23/2025, and a diagnoses list that included a traumatic subdural hemorrhage with loss of consciousness of unspecified duration, sequela, traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela, encounter for attention tracheostomy.During an interview on 1/8/2026 at 11:31 am Infection Preventionist (RN6), acknowledged that the tracheostomy tubing should not come into contact with the floor due to contamination risk. RN6 went on to report another reason the tubing should not be on the floor, was because the floor was considered dirty, and the residents were already immunocompromised.During an interview on 1/8/2026 at 11:46 am Licensed Practical Nurse (LPN 12), reported that they do rounds three times a shift and that they checked tracheostomy residents and if the tubing was on the floor.During an interview on 1/8/2026 at 12:04 pm LPN 12 disclosed that if something touched the floor then the expectation was to get something clean to replace it.During an interview on 1/8/2026 at 12:52 pm Assistant Director of Nursing (ADON) stated the staff are not supposed to have anything on the floor. The ADON was unable to explain how the tubing was consistently maintained off the floor.