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	06/17/2026

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 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. Based on medical record review and interviews, it was determined that the facility failed to ensure that allegations of abuse were reported to the State Agency no later than 2 hours after the allegation was made. This was evident in one (Complaint #3026441) of 2 Complaints investigated during the complaint survey. The findings include:A review of Complaint #3026441 related to Resident#1 noted an allegation that staff #4, a nursing assistant, had assaulted Resident #1 by slapping him/her while giving the resident a bed bath (washing the Resident in bed). A continued review showed that the allegation was reported to the facility staff members; however, the state agency had not received a report of the alleged abuse from the facility. A review of Resident #1's medical record showed that he/she had a tracheostomy (a surgically created opening in the neck that bypasses the nose, mouth, and throat to help with breathing). The Resident also had left-sided weakness due to a history of stroke, did not walk, was bedbound, and relied on staff for all self-care needs. The review also indicated that Resident #1 was alert but nonverbal due to aphonia (loss of voice); however, he/she communicated through signs and gestures and by mouthing words. In an interview with Resident #1 on 6/17/26 at 11:04 AM, the surveyor read the summary of the complaint reported by the resident's representative. Resident #1 nodded yes to indicate agreement with the allegation. The resident was asked how he/she was assaulted and gestured to indicate he/she was slapped in the right cheek. The surveyor asked Resident #1 a follow-up question to confirm whether he/she meant he/she had been slapped by a staff member, and Resident #1 nodded yes. During an interview on 6/17/26 at 2:32 PM, staff #3, the social service director, reported that Resident #1 had made the allegation to staff #7, a social worker, on 5/14/26 in the presence of the Resident's representative. Staff #7 reported it to the nursing home administrator (NHA) the same day. However, when the NHA spoke with Resident #1, he/she decided to retract the allegation, so the facility determined that no further action was necessary. An interview with the Regional Director of Operations on 6/17/26 at 2:59 PM found no evidence that the allegation of abuse involving Resident #1 had been reported to the state agency office.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215145	A. Building B. Wing	06/17/2026

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interviews, it was determined that the facility failed to ensure that thorough investigations were completed for allegations of abuse. This was evident in one (Complaint #3026441) of 2 Complaints investigated during the complaint survey. The findings include:A review of Complaint #3026441 related to Resident #1 noted an allegation made on 5/14/26 that Resident #1 had been slapped by staff #4, a nursing assistant, during care on 5/13/26 while staff #4 was giving the resident a bed bath (washing the Resident in bed). Further review of the facility's investigation into the allegation revealed interviews with other residents on the same nursing unit where Resident #1 resided, as well as a statement signed by the assistant administrator and the assistant director of nursing. The review showed that some of the residents interviewed were unable. A continued review of the staffing schedule for the day of the allegation showed that the perpetrator had worked with two other staff members on that shift. However, the review failed to demonstrate that the facility had conducted a thorough investigation, including a head-to-toe assessment of Resident #1 and of the other residents who were unable to be interviewed. The facility's investigation also lacked written statements from staff #4, the perpetrator, and from staff members who had worked with staff #4 that day and may have been aware of the incident. A review of the facility's policies and procedures on Abuse, Neglect, Exploitation found that the facility will protect residents from harm during an investigation by immediately removing the alleged perpetrator from the resident care areas. However, an interview on 6/17/26 at 3:30 PM with staff #4 showed that she continued working with residents from 5/14/26, when the allegation was made, and was not removed from the residents' care areas.