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	09/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews it was determined that the facility failed to ensure Residents were provided a dignified existence. This was found to be evident for 6 (Resident #126, #18, #162, #114, #229, & #183) out of 7 Residents observed for dignity during the recertification survey.The findings include: 1) During an interview conducted on 09/15/2025 at 8:17 AM, Resident #126 stated that when staff enter the room they do not introduce themselves and ask permission to enter. During an interview conducted on 09/15/2025 at 8:43 AM this Surveyor observed Geriatric Nursing Assistant (GNA)#8 knock on Resident #126's door once and then entered the room without introducing herself and asking for permission to enter. During an interview conducted on 09/15/2025 at 8:46 AM, GNA#8 stated that she should have said who she was and asked if she could enter. She further stated that it is the facility's policy to introduce yourself and ask permission to enter. 2) During an interview conducted on 09/16/2025 at 10:36 AM, Resident #18 stated that the staff do not ask for permission to enter his/her room. The Resident stated that sometimes the staff do even knock they just walk in my room.During the continued interview with Resident #18, Unit Manager #33 knocked on the Resident's door one time and entered the Resident's room. The Unit Manager did not announce herself and asked for permission to enter.During an interview with the Unit Manager conducted on 09/16/25 at 10:43 AM, the Unit Manager apologized for not announcing herself and asking permission to enter the Resident's room. She further stated that the facility's expectation is to treat each resident with respect for their home by knocking on the door, announcing themselves, asking for permission and waiting for the Resident's response in giving permission to enter their room. 3) A urinary Foley bag refers to the urine collection bag attached to a Foley catheter, a flexible tube inserted into the bladder to drain urine when a person cannot urinate normally. The Foley catheter system includes the tube, a small balloon to keep it in place inside the bladder, and a drainage tube leading to the collection bag, which can be worn on the leg or a larger night bag for overnight use. During an observation conducted on 09/15/2025 at 7:42 AM, the Surveyor observed Resident #126's urinary foley bag lying flat on the floor, full of urine, and without a privacy bag. Continued observations were conducted on 09/16/25 at 9:09 AM, 09/18/25 at 8:14 AM & 09/19/25 at 8:39 AM that showed Resident #126's urinary foley bag lying flat on the floor and without a privacy bag. On 09/16/25 at 10:55 AM, this Surveyor observed License Practical Nurse (LPN) #29 attached Resident #126's urinary foley bag to a hook under the Resident's motorized wheelchair as he/she was leaving to attend an outside medical appointment. The urinary foley bag did not have a privacy covering. During an interview with LPN #29 conducted on 09/16/25 at 10:57AM, the LPN stated that she could not access the supply room to retrieve a privacy urinary foley bag. During an interview conducted on 09/17/25 at 6:32 AM, this Surveyor advised the Director of Nursing (DON) of the observations of the lack of a privacy urinary foley bag. The DON stated that he would educate the staff on providing a privacy urinary foley bag. 4) During an observation of Resident #162's medication administration conducted on 09/17/25 at 8:08 AM, Licensed Practical Nurse (LPN) #31 administered escitalopram 20 mg (milligram), escitalopram 10 mg, metamucil, and Rena Vite 0.8 mg to the Resident. The LPN failed to inform the Resident of the medications that were to be administered. During an observation of Resident #114's medication (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration conducted on 09/17/25 at 8:27 AM, Licensed Practical Nurse (LPN) #31 administered metformin hydrochloride 500 mg, metoprolol succinate 50 mg, finasteride 5 mg, B-12 100 mcg losartan potassium 25 mg, tiotropium bromide hydrate 18 mcg (microgram), and fluticasone propionate salmeterol 100-50 mcg to the Resident. The LPN failed to inform the Resident of the medications that were to be administered. During an interview conducted on 09/17/25 at 8:40 AM, the LPN stated the she should have informed the Residents of their medications.5) During an observation of Resident #229's medication administration conducted on 09/17/25 at 8:47 AM, Registered Nurse (RN) #32 administered clonazepam 0.5 mg, lacosamide 10 mg, valporate acid 250 mg/5 ml solution, oxcarbazepine 600 mg, multivitamin, atenolol 25 mg, and levETIRAcetam 100 mg to the Resident. The RN failed to inform the Resident of the medications that were to be administered. 6) During an observation of Resident #183's medication administration conducted on 09/17/25 at 9:18 AM, RN#32 amlodipine 5 mg, fluoxetine 20 mg, oxybutynin 10 mg, oxybutynin 5 mg, Xarelto 20 mg, and oxycodone hydrochloride 10 mg to the Resident. The RN failed to inform the Resident of the medications that were to be administered.During an interview conducted on 09/17/25 at 9:36 AM, the RN acknowledged that he did not inform the Residents of the medications administered. He stated that the expectation is to inform the Resident of all medication administered.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, it was determined that the facility failed to 1. have quarterly Care Plan Meetings with the Interdisciplinary Team, 2. ensure care plan meetings were held in a timely manner and 3. review and revise the care plan to meet resident's needs. This was found to be evident for 5 (Resident #140, #120, #201, #232 and #285) out of 11 residents reviewed for care planning during the annual survey.The findings include:1.Care Plan Meetings are meetings with a team of care providers including the attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of food and nutrition services, the resident, and the resident's representative if applicable to ensure the care plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. During an interview with Resident #140 on 09/16/25 at 10:54 AM he/she denied having any recent care plan meetings. During a medical record review on 09/18/25 at 8:13 AM it was discovered that Resident #140 hadn't had a care plan meeting since 03/23/25. The last two care plan meetings were held on 07/02/24 and 03/23/25. He/she didn't have any care plan meetings between 07/03/24 and 03/22/25. The Resident only had one care plan meeting in 2025 and that meeting occurred on 03/23/25. During an interview with the Social Work Director on 09/18/25 at 1:37 PM the Director advised care plan meetings should be completed every three months. The Director confirmed that there were care plan meetings missed for Resident #140. The Director was not sure why the care plan meetings were not completed because Resident #140 was covered by a previous social worker that was no longer at the facility. 2. During a medical record review on 09/18/25 at 7:30 AM it was discovered that Resident #120 had not had a care plan meeting since 03/06/25. During an interview with the Social Work Director on 09/18/25 at 1:33 PM the Director confirmed that there was a care plan meeting missed for Resident #120. The Director reported Resident #120 should have had a care plan meeting in June and was due for another in September. The Social Work Director reported I can't give an answer as to why it was missed since Resident #120 was covered by a previous social worker that was no longer at the facility at that time. 3. During a medical record review on 09/18/25 at 10:43 AM it was discovered that Resident #201 had a care plan meeting on 06/18/24 and no other care plan meetings until 03/20/25. No care plan meetings were found from 06/19/24 through 03/19/25 and no care plan meetings were found from 03/21/25 until the interview with the Social Work Director on 09/18/25. During an interview with the Social Work Director on 09/18/25 at 1:56 PM the Director advised care plan meetings should be completed every three months. The Director confirmed that there were care plan meetings missed for Resident #201. The Director agreed that Resident #201 should have had a care plan meeting in September 2024, December 2024, June 2025 and was due for one in September 2025. The Social Work Director reported they were unsure the care plan meetings were missed for Resident #201 because he/she was covered by a previous social worker that was no longer at the facility during that time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to CMS (Centers for Medicare & Medicaid Services) care plan meetings, which are part of the comprehensive care planning process for long-term care facilities, require regular review and revision based on resident assessments. These meetings ensure that residents receive person-centered care that meets their individual needs and preferences. During an interview conducted on 09/16/25 at 9:49 AM, Resident #232's Power of Attorney (POA) reported that he/she did not have quarterly care plan meetings. A review of Resident #232's care conference notes were conducted on 09/23/25 at 9:08 AM showed the following Care Plan meetings were held on 06/11/24, 04/03/25, and 05/29/25. On 09/23/25 at 9:30 AM this Surveyor requested Care Plan meeting notes from 09/24 through 09/25. On 09/24/25 at approximately 11:00 am the Director of Nursing (DON) provided the Care Plan meeting notes. A review of the Care Plan meeting notes revealed that there were 2 Care plan meetings held for Resident #232 from 09/24 through 09/25. There was a Care Plan meeting held on 04/03/25 and 05/29/25. During an interview, the DON reported that the Care Plan Meetings notes for the period of 09/24 through 09/25 showed a Care Plan meeting was held on 04/03/25 and 05/29/25. This Surveyor expressed concern that the Resident and/or Resident Representative had not received quarterly Care Plan meetings. 5. According to CMS (Centers for Medicare and Medicaid Services), in long-term care facilities, care plans should be reviewed and updated at least every 90 days, or more frequently if a resident's condition changes significantly. On 9/23/25 at 9:32 AM, a review of Resident #285's progress notes revealed multiple falls on 1/30/25, 2/17/25, 3/17/25, 6/7/25 and 7/31/25. However, the fall risk evaluation dated 2/17/2025, indicated a score of 5, classifying the Resident which as low risk. On 9/23/25 at 9:52 AM, a review of Resident #285's care plan, initiated on 2/3/2025 indicated an actual fall related to gait imbalance. Although the Resident experience multiple falls during their stay, there was no evidence that the care plan was updated after the fall on 3/17/25. On 9/24/25 at 10:09 AM, in an interview with the Director of Nursing (DON), he stated that the care plans were updated by the Unit Managers and himself. He also noted that it was expected for the care plan interventions to be updated after each fall incident. On 9/24/25 at 11:11 AM, the DON provided the surveyor with a copy of Resident #285's fall care plan with revisions and acknowledged the concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 with facility staff, it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This was evident during the initial tour of the kitchen during the annual survey.The findings include:During an initial tour of the kitchen on 09/15/25 at 8:44 AM, the surveyor and Certified Dietary Manager (CDM) observed the following opened and unlabeled items in the walk-in freezer: one box of pizza dough, one box of tortilla chips, one box of hamburger patties, and one box of French toast.In an interview conducted on 09/16/25 at 8:58 AM, the CDM confirmed the faility's food storage policy is to securely close packages once opened and to label the package with an open date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined that the facility failed to 1) ensure appropriate personal protective equipment (PPE) was readily accessible and used by staff prior to entering the room of a resident on transmission based precautions, 2) ensure staff practiced infection control, 3) ensure that the environment was maintained in a manner that minimized the potential spread of infection and 4) ensure appropriate infection prevention and control practices were followed. This was evident for 1) 1 out of 2 residents (Resident #288) reviewed for transmission-based precautions, 2) 2 out of 7 residents (Resident #126, #150) observed for infection control, 3) 1 random observation of the laundry room, and 4) 1 out of 46 residents (Resident #14) reviewed during the annual survey.The findings include: 1) On 09/18/25 at 8:25 AM, the surveyor observed GNA #26 enter Resident #288's room (210A) without donning a gown, gloves, or N95 mask. Signage posted on the resident's door clearly indicated the need for contact and droplet precautions. GNA #26 was wearing only a surgical mask. In an interview on 09/18/25 at 8:27 AM, GNA #26 stated she believed PPE was only needed in Resident #288's room when providing direct care. In an interview on 09/15/25 at 8:55 AM, the surveyor raised concerns with the Infection Preventionist, who stated that staff are expected to don full PPE, including a gown, gloves, and an N95 mask, before entering the room of any resident on droplet precautions. In an interview on 09/19/25 at 6:50 AM, Unit Manager #1 confirmed there were no N95 masks on the PPE cart outside of room [ROOM NUMBER]A and stated that N95 masks were stored on the locked medication cart. Unit Manager #1 also stated that nursing staff would provide N95 masks to visitors and staff when requested. At 6:53 AM, the surveyor observed N95 masks being added to the PPE cart for room [ROOM NUMBER]A after the issue was discussed. In an interview on 09/19/25 at 7:39 AM, the Director of Nursing (DON) stated that the facility keeps N95 masks on the locked medication cart so residents don't touch them. The DON also stated that staff or anyone entering the room needs to ask the nurse for an N95 mask before going in. The DON further stated the expectation is that nurses are monitoring who is going into the room and will provide the mask. When the surveryor asked if there was a sign on the door directing staff or visitors to request N95 masks from nursing staff, the DON said no. 2) A urinary Foley bag refers to the urine collection bag attached to a Foley catheter, a flexible tube inserted into the bladder to drain urine when a person cannot urinate normally. The Foley catheter system includes the tube, a small balloon to keep it in place inside the bladder, and a drainage tube leading to the collection bag, which can be worn on the leg or a larger night bag for overnight use. A urinary foley bag should be hung below the level of the bladder, such as on the side of a bed frame, a bed or a chair, or inside a clean trash can, to ensure proper gravity drainage. It must be kept off the floor to prevent contamination and infection. During an observation conducted on 09/15/2025 at 7:42 AM, the Surveyor observed Resident #126's urinary foley bag lying flat on the floor, full of urine, and without a privacy bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 09/15/2025 at 8:11 AM, Registered Nurse (RN) # 9 entered Resident #126's room. This Surveyor pointed out to the RN that the urinary foley bag lay flat on the floor. The RN stated that she would hang the bag on the bottom bar under the Resident's bed. Continued observations were conducted on 09/16/25 at 9:09 AM, 09/18/25 at 8:14 AM & 09/19/25 at 8:39 AM that showed Resident #126's urinary foley bag lying flat on the floor. During an interview conducted on 09/17/25 at 6:32 AM, this Surveyor advised the Director of Nursing (DON) of the observations of the observations of the foley bag lying on the floor. The DON stated that he would educate the staff on placement of the foley bag. On 09/22/2025 at 11:13 AM the DON returned and showed this surveyor a text message from the Unit Manager that stated that Resident #126 requested that the urinary foley bag be on the floor because it drained better. The DON stated it was the Resident's right. This Surveyor stated that the facility had an obligation to practice safe care and to educate the Resident on infection control. It also was the responsibility of the facility to find out why the Resident reported the that the foley bag drained better lying on the floor. On 09/22/2025 at 1:07 PM the DON returned and stated that he spoke to the Resident and the Resident confirmed that the urinary foley bag drained better on the floor. The DON stated that he advised the Resident that it was a concern and would notify the physician to assess placement and to rule out an occlusion. The DON further stated that he educated the Resident on the infection control concern when the bag lay on the floor. During an observation conducted on 09/15/25 at 8:05 AM, Resident #126 had a sign on the entry door that stated EBP (Evidence Based Practice) Precautions. The sign had direction for direct care. When providing direct care you are required to wear PPE (personal protective equipment) that consists of gown and gloves. During an interview conducted on 09/15/25 at 8:06 AM the Resident reported that he/she needed to speak with the nurse because he/she did not feel well. This Surveyor observed a large amount of mucus dripping from his/her nose that dripped down the Resident's face and onto the chin. This Surveyor observed the Resident press the call bell on 09/15/25 at 8:08 AM. During an observation on 09/15/25 at 8:39 AM, Geriatric Nursing Assistant (GNA) #8 entered the Resident's room without wearing PPE. The Resident asked the GNA if she could clean his/her face, nose and chin to remove the mucus. The GNA placed one glove on her hand and cleaned the Resident. During an interview conducted on 09/15/25 at 8:41 AM, this Surveyor asked GNA #8 if she was aware that the Resident was on a precaution. The GNA stated yes but she did not need to wear the PPE because she was just cleaning the Resident. During an interview conducted on 09/17/25 at 6:39 AM, this Surveyor notified the DON of the observation and GNA #8's response to not having to wear PPE when providing direct care. The DON informed the Surveyor that he would speak to the GNA and provide education on EBP precautions. During an observation of a medication administration conducted on 09/17/2025 at 9:18 AM this Surveyor observed Registered Nurse (RN) #32 obtain Resident #183's blood pressure with a shared blood pressure cuff. The RN then went to Resident #150's room and obtained his/her blood pressure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using the same blood pressure cuff that was used on Resident #183. The RN failed to sanitize the blood pressure cuff and equipment prior to obtaining Resident #150's blood pressure. During an interview conducted on 09/17/2025 at 9:37 AM, RN #32 acknowledged that he did not sanitize the community shared blood Pressure cuff and equipment prior to using it on Resident #150. Unit Manager #33 was present during interview and advised the Surveyor that she would provide education to the staff in practicing infection control. 3) During an observation of the laundry room on 09/22/25 at 7:51 AM it was observed that Housekeeper #27 was folding laundry. During the folding process several observations were made of the bottom of the sheets and gowns touching the floor while being folded. During an observation and interview with the Housekeeping Assistant Manager on 09/22/25 at 8:01 AM she agreed that linen should not touch the floor when being folded. She expressed the concern to Housekeeper #27 who then used the folding table which kept the linens off the floor while being folded. 4) Resident #14 was admitted to the facility with diagnoses including Chronic Respiratory Failure with Hypoxia and End Stage Renal Disease. On 09/15/25 at 9:31 AM during initial rounds the surveyor observed a nebulizer machine on the floor next to Resident #14's bed. On 09/15/25 at 9:55 AM the surveyor notified the Nurse Staff Educator who visited the resident's room and confirmed the findings. On 09/18/2025 at 8:03 AM a review Resident #14's clinical record revealed a physician's order for respiratory therapy as follows: Respiratory Therapy (RT) - Evaluation & treatment as recommended Order Date 08/06/25. 09/18/2025 at 10:21 AM during an interview the Director of Nursing informed the surveyor that he was made aware of the surveyor's findings and had conducted an Inservice training on 09/16/25 to educate the staff that Nebulizer machines must not be placed on the floor. The DON gave the surveyor a copy of the Inservice document.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews it was determined the facility failed to ensure a call bell was answered in a timely manner. This was found to be evident for 1 (Resident #126) out of 1 Resident observed for call bell response time during the recertification survey.The findings include: During an interview conducted on 09/15/2025 at 8:06 AM, Resident #126 stated that he/she is fully dependent on the staff for all his/her needs. The Resident stated that staff response time to call bells was very delayed. The Resident stated that he/she requested to leave the door open halfway to be able to call out for help after waiting long periods of time when he/she pushes the call bell and it goes unanswered. The Resident reported that he/she needed to speak with the nurse because he/she did not feel well. This Surveyor observed a large amount of mucus dripping from his/her nose that dripped down the Resident's face and onto the chin. This Surveyor observed the Resident press the call bell on 09/15/25 at 8:08 AM. The Resident entry door was halfway open. This Surveyor and the Resident observed 3 staff walk pass the Resident's door however no one came to answer the Resident's call bell. The Resident informed this Surveyor that one of the staff that walked passed the room was the Unit Manager. During the continued interview and screening of the Resident, this Surveyor observed at 8:39 AM Geriatric Nursing Assistant (GNA) #8 enter the Resident's room. The GNA stated that she was with another Resident. The Resident asked the GNA if she could clean his/her face, nose and chin to remove the mucus. The GNA cleaned the Resident and asked if the Resident needed anything else. The Resident asked the GNA if she could have the nurse come to see him/her, she agreed and exited the Resident's room. On 09/15/25 at 8:42 AM Registered Nurse (RN) #9 entered the Resident's room. The Resident notified the nurse that he/she did not feel well. The RN stated that she would obtain vitals and conduct an assessment. During an interview this Surveyor expressed concern that there was a 31-minute call bell response time. The RN reported that she saw the call bell light on, but she was conducting medication administration at the time. She further stated that she saw the Unit Manager in the hallway and assumed the Resident's needs had been addressed. On 09/17/25 at approximately 8:00 AM, this Surveyor reported the observation of the delayed call bell response time to the Director of Nursing (DON). The DON stated that he would investigate the matter.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews and record reviews it was determined that the facility failed to ensure showers were provided for a Resident. This was found to be evident for 1 (Resident #126) out of 1 Resident reviewed for self-determination during the recertification survey.The findings include: During an interview conducted on 09/16/2025 at 8:15 AM, Resident #126 reported that he/she had not received showers although he/she had requested showers. A care plan meeting in a nursing home is a quarterly, person-centered discussion among a resident, their family, and the nursing home's interdisciplinary team to review and update the resident's personalized care plan. The goal is to ensure the care plan meets the Resident's current physical, medical, emotional, and personal needs and preferences, fostering their well-being and maintaining their independence. During an interview conducted on 09/17/25 at 10:43 AM the Resident's family member stated that the Resident had not been offered showers. He/she further stated that it was discussed in the Care Plan meeting a week ago.A Care Plan is a comprehensive document that outlines the specific healthcare needs, goals, and interventions for an individual patient. It serves as a roadmap for healthcare providers, ensuring coordinated and personalized care. A review of Resident #126's Care Plan conducted on 09/17/25 at 11:00 AM showed a Care Plan for the Resident's refusal of showers. During an interview conducted on 09/19/2025 at 7:20 AM the Director of Nursing (DON) explained the facility's shower policy. He stated that all Residents are scheduled 2 showers a week unless contraindicated. A physician order is placed with the days of the week and shift that the showers were provided. When asked if Resident #126 had been offered showers the DON stated that the Resident had been offered showers but had refused. This Surveyor requested documentation of the refusal. A review of the Resident #126's physician orders conducted on 09/19/25 at 07:24 AM, it was discovered that the Resident did not have an order for showers. Activities of Daily Living (ADLs) are fundamental self-care tasks, such as bathing, dressing, and eating, that are necessary for independent living and are often used in healthcare to assess a person's functional abilities. ADL task is a form that is completed by nursing staff that documents ADLs that were performed. A review of Resident #126's ADL task form for the last 30 days conducted on 09/19/2025 at 8:05 AM showed that the Resident did not refuse baths/showers. During an interview conducted on 09/19/25 at approximately 9:00 AM, the DON stated that the he had been advised that the Resident refused showers and as a result the Resident had a Care Plan for refusing showers. However, the DON confirmed that there was no documentation that the Resident refused showers. The DON and this Surveyor reviewed Resident #126's physician orders, the DON confirmed that the Resident did not have active order for showers. This Surveyor expressed concern that without an order for a shower how would the staff know to offer a shower. The DON agreed and stated that he would have an order placed for showers.On 09/19/25 at approximately 11:15 AM the DON returned and reported to this Surveyor that he spoke with Resident #126 and stated that the Resident expressed that he/she wanted to have showers. The DON stated that he advised the Resident that he would make sure the Resident was offered an opportunity to have a shower. The DON further stated that the Resident now had an order for showers.

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Complete Care at Hyattsville	4922 Lasalle Road Hyattsville, MD 20782

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed to ensure that Advance Directives were discussed with residents and/or responsible representatives. This was for 1 (Resident #2) of 8 residents reviewed for Advance Directives.The findings include:Resident # 2's clinical record revealed that the resident was admitted to the facility in [DATE] and their most recent re-admission was in [DATE]. The resident's diagnoses include Anoxic Brain Damage and End Stage Renal Disease.On [DATE] at 3:22 PM a review of Resident #2's clinical record revealed a MOLST (Maryland Orders for Life-Sustaining Treatment) form. The MOLST, which was dated [DATE], revealed verbal consent by the resident's Responsible Representative for CPR in the event of cardiac and/or pulmonary arrest (CPR). The clinical record failed to reveal the presence of an Advance Directive or that the Advance Directive was discussed with the Resident and/or Responsible Representative.Further, a review of the resident's Social Services assessments dated [DATE] and [DATE], Section A #5 of Social Services Assessment and Documentation revealed that information was not provided to Resident and/or Responsible Representative on Advance Directive.On [DATE] at 12:26 PM during an interview, the Social Services Director (SSD) stated that Advance Directive, is discussed upon admission/readmission, and at care conferences and educational material is offered. Further, information regarding the status the resident's Advance Directive is documented under Section A #5 of Social Services Assessment and Documentation. The SSD reviewed Resident #2's clinical Record and confirmed the surveyor's findings.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure the Ombudsman was notified of transfers and discharges. This was found to be evident for 2 (Resident #88 & #232) out of 2 Residents reviewed for hospitalization during the recertification survey.The findings include: During a review of Resident #88's medical record conducted on 09/18/2025 at 8:18 AM it was discovered that the Resident experienced a medical emergency and was transferred to a local hospital on [DATE]. During a review of Resident #232's medical record conducted on 09/18/25 at 8:47 AM it was discovered that the Resident was transferred to a local hospital on [DATE]. During an interview conducted on 09/18/25 at approximately 9:00 AM, this Surveyor asked the Nursing Home Administrator (NHA) to provide the Ombudsman notification for transfers and discharges.On 09/18/25 at approximately 11:45 AM the Nursing Home Administrator (NHA) provided this Surveyor with a printout of an email dated 09/18/25 at 11:26 AM from the Social Service Director to the Ombudsman. A review of the email showed 8 attachments and a note that stated, Please see attached discharge transfer report from January 2025 to the present. During an interview, the NHA acknowledged that the notification to the Ombudsman was emailed after this Surveyor requested the notification. During an interview conducted on 09/18/25 at approximately 1:30 PM, the Social Service Director reported that he had not provided notification of transfers and discharges to the Ombudsman since March 2024.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS) Assessments were accurately coded for residents. This was evident for 2 (Resident #123 and #168) out of 46 sampled residents reviewed during the annual survey. The findings include: Minimum Data Set (MDS) is a federally mandated comprehensive clinical assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. 1.On 09/19/2025 at 3:05 PM, a review of Resident #168's clinical record revealed the following physician order: Date 03/21/2025 for ADMIT to Hospice of the Chesapeake with a hospice diagnosis. Further review of Resident #168's clnical record showed that a Significant Change MDS assessment was completed on 03/31/25, and under section O, the resident was coded as receiving hospice care. However, a review of a subsequent MDS quarterly assessment dated [DATE] indicated that in section O, hospice care was marked as No. On 09/22/2025 at 10:19 AM an interview with MDS Coordinator #24 confirmed the MDS inaccuracy and stated that it was an oversight. MDS Coordinator #24 further stated that the hospice coding should have been marked as Yes for Resident #168 and that she would modify/correct the MDS quarterly assessment. 2. An ostomy is any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste. During a review of medical records conducted on 09/22/25 at 11:42 AM it was revealed that the MDS assessment dated [DATE] for Resident #123 recorded that he/she had and Ostomy in Section H – Bladder and Bowel. The MDS Assessment had been signed off as completed on 09/04/25. During a continued review of medical records for Resident #123 it was discovered that he/she did not have an ostomy documented in his/her medical records. During an interview with the MDS Manager #24 on 09/22/25 at 2:01 PM she confirmed that the resident did not have an ostomy and it was inaccurately coded. The box should not have been checked showing that Resident #123 had an ostomy. During a medical record review for Resident #123 on 09/23/25 at 5:34 PM it was discovered the MDS Assessment had been corrected and no longer identified the resident as having an Ostomy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review and interviews, it was determined the facility failed to provide residents and/or responsible representatives with summaries of their Baseline Care Plans. This was evident for 2 (Resident #3 and #14) of 46 residents reviewed during the annual /recertification survey.The findings include:A Baseline Care Plan must be completed within 48 hours of a resident's admission to the facility and must include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the baseline care plan as well as a list of the resident's current medications must be given to each resident and/or their responsible representative.Resident #3 was admitted to the facility in June 2025 with diagnoses including Chronic Respiratory Failure and Anoxic Brain and is ventilator dependent.On 09/18/25 at 10:55 AM the surveyor reviewed Resident #3' clinical record. The record failed to reveal any evidence that the resident's Baseline Care Plan was discussed with the Resident and/or Responsible Representative and a copy given to them.On 09/19/25 at 8:42 AM during an interview the Director of Social Services stated that Baseline Care Plans(BCPs) are developed within 48 hours of a resident's admission to the facility. The Care Team, which includes the Social Worker and Unit Manager, would discuss the BCPs with the Resident and/or Responsible Representative and a copy would be given to them.The Director of Social Services reviewed Resident #3's clinical resident's record and confirmed the surveyor's findings stating, there is no record to show that it was done. 2) Resident #14 was admitted to the facility in August of 2025 and was his own Responsible Party.On 09/18/2025 at 11:10 AM a review of the resident's clinical record failed to reveal any evidence that Resident #14's Baseline Care Plan was discussed with him/her and that a copy was given to him/her. 09/19/2025 at 8:42 AM during an interview the Director of Social Services reviewed Resident #14's clinical record and confirmed the surveyor's findings.

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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 interviews and record reviews it was determined the facility failed to ensure Resident Care Plans were developed. This was found to be evident for 1 (Resident #6) out of 1 Resident reviewed for Care Plans during the recertification survey.The findings include: A Care Plan is a comprehensive document that outlines the specific healthcare needs, goals, and interventions for an individual patient. It serves as a roadmap for healthcare providers, ensuring coordinated and personalized care. During a record review conducted on 09/22/25 at 12:43 PM, it was discovered that Resident #6 had a diagnosis of schizoaffective disorder. During a review of Resident #6's Care Plan conducted on 09/22/2025 at 1:10 PM it was discovered that the Resident did not have a care plan for schizoaffective disorderDuring an interview conducted on 09/22/25 at approximately 1:30 PM, this Surveyor and Director of Nursing (DON) reviewed Resident #6's Care Plan with revisions. The DON confirmed that the Resident did not have a Care Plan for a schizoaffective disorder. The DON stated that he would add a Care Plan with interventions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure staff provided services that met professional standards of practice. This was found to be evident for 1 (Resident #88) out of 1 Resident reviewed for services meet professional standards of practice during the recertification survey.The findings include: During a review of Resident #88's medical record conducted on 09/18/2025 at 8:18 AM it was discovered that the Resident experienced a medical emergency and was transferred to a local hospital on [DATE]. A review of Resident's #88 medical records conducted on 09/18/25 at 8:35 AM revealed a physician certification form dated 06/05/23. The form deemed the Resident unable to understand and sign admission documents and other information, unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, unable to make rational evaluation of the burdens, risks, and benefits of the treatment, unable to effectively communicate a decision. The form was signed by 2 physicians. On 09/22/25 at 6:30 AM this Surveyor requested Resident #88's bed hold notice for the transfer to the hospital on [DATE]. On 09/22/25 at 8:00 AM, the Director of Nursing (DON) provided this Surveyor with a Maryland Bed Hold Policy, Temporary Bed Hold Authorization, and Authorization to Record. A review of the Temporary Bed Hold Authorization showed a box checked that stated I do not wish to authorize the Facility at this time to retain my/the Resident's bed if I/the Resident is hospitalized or goes on therapeutic leave. However, should the Resident be hospitalized or go on therapeutic leave, I will be consulted at the time as to whether or not I would choose to hold the bed. The form was signed by Resident #88 on 04/15/25 at 3:19 PM EDT. The Facility Representative Name and signature was that of the admission Coordinator. The admission Coordinator signed the form on 04/15/25 at 3:42 PM EDT. A review of the Authorization to Record form had a box checked off that stated I hereby authorize the Facility or any of its staff to take photographs or other audio-visual images for use on the facility's social media or other marketing materials. The form was signed by Resident #88 on 04/15/25 at 3:19 PM EDT. The Facility Representative Name and signature was that of the admission Coordinator. The admission Coordinator signed the form on 04/15/25 at 3:42 PM EDT. During an interview with the Nursing Home Administrator (NHA) conducted on 09/22/25 at approximately 9:15 AM, this Surveyor expressed concern that Resident #88 was certified as not having capacity to understand and sign documents. The NHA stated that he understood the Surveyor's concern and would have the admission Coordinator come to speak to the Surveyor. During an interview conducted on 09/22/25 at approximately 10:00 AM the admission Coordinator reported that she needed to close out the forms, so she had the Resident to sign the forms. She further stated that she understood that the Resident did not have the capacity to understand and sign the forms. This Surveyor expressed concern about the admission Coordinator's professional standards of practice. The Surveyor stated that it was unacceptable to have a Resident sign a form who had been certified by physicians to not have capacity to understand and to sign forms.

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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, interview and record review, it was determined that the facility failed to provide Activities of Daily Living (ADL) care to a dependent resident. This was found evident for 1 (Resident #20) out of 1 resident reviewed for ADL care. The findings include:According to the Centers for Medicare & Medicaid Services (CMS), the facility must provide care and services to assist residents with Activities of Daily Living (ADLs), including hygiene, mobility, elimination (toileting), dining, and communication. According to CMS, Oral care refers to the maintenance of a healthy mouth, which includes not only teeth, but the lips, gums, and supporting tissues. This involves not only activities such as brushing of teeth or oral appliances, but also maintenance of oral mucosa.According to CMS, a dependent resident is an individual who requires staff assistance to complete all or most Activities of Daily Living (ADLs) because they are unable to perform these tasks independently. This may include total dependence, where staff provide full physical assistance for care such as bathing, dressing, toileting, transferring, eating, or mobility.On 09/16/2025 at 9:11 AM, an observation of Resident #20 in his/her room showed that the Resident's teeth contained food particles.On 09/17/2025 at 9:34 AM, during an interview with Resident #20's representative, he/she stated that he/she did not believe the facility was adequately brushing the Resident's teeth.On 09/17/2025 at approximately 12:00 PM, a record review of Resident #20's Minimum Data Set (MDS), under the Functional Abilities section, showed that for Oral hygiene, the Resident was documented as Dependent. On 09/22/2025 at 11:22 AM, another observation of Resident #20 showed pieces of food stuck to the Resident's teeth.On 09/22/2025 at 11:25 AM, an interview was conducted with Geriatric Nursing Assistant (GNA) #21 in Resident #20's room. GNA #21, who was assigned to the Resident on this day, stated that she normally completed ADL tasks, including brushing teeth, after breakfast. She reported that breakfast for the residents on this floor is typically served at 8:00 AM. GNA #21 confirmed that the last time she had worked with Resident #20 was on 09/19/2025 and that she had not provided oral care during that shift because the Resident was asleep for most of the day. She further confirmed that it is expected for oral care to be completed for residents at least once daily.On 09/22/2025 at 11:54 AM, an interview was conducted with Unit Manager #6 regarding the expectations for oral care. He stated that it is his expectation for residents to have their teeth brushed daily. On 09/22/2025 at 12:00 PM, another observation of Resident #20 in his/her room showed that food particles were still present on the Resident's teeth.On 09/22/2025 at approximately 12:02 PM, a follow-up interview was conducted with Unit Manager #6. When asked about the expectation for providing oral care to a resident who is asleep, he stated that oral care is still expected to be completed even if the resident is sleeping for extended periods. He explained that the GNA can use a wetted sponge with fluoride to gently sweep along the inside of the resident's mouth to clean it while the resident is asleep.On 09/22/2025 at 12:29 PM, this surveyor conducted an interview with Unit Manager #6. The surveyor explained that multiple observations had been made of Resident #20 with food particles in the mouth and teeth appearing unbrushed. GNA #20 confirmed in an interview that she had not brushed Resident #20's teeth on 09/19/2025 because the resident was asleep. The surveyor explained that this is a concern, as it appears this dependent Resident is not receiving oral care at least once a day as expected by the Unit Manager, even when there are methods available to provide oral care while residents are sleeping. The Unit Manager acknowledged the concern, stated he understood, and reported he would ensure the Resident's teeth are brushed as required.On 09/22/2025 at 2:14 PM, this surveyor conducted an interview with the Administrator. The surveyor brought to the Administrator's attention the concern that a dependent resident was not receiving oral care. The Administrator acknowledged the concern and confirmed that it is his expectation that residents have their teeth brushed at least twice a day.

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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 interviews and record reviews it was determined that the facility failed to ensure a Resident received treatment as ordered for a pressure ulcer. This was found to be evident for 1 (Resident #126) out of 1 Resident reviewed for pressure ulcer during the recertification survey.The findings include:A pressure ulcer is damage to an area of the skin caused by constant pressure on the area for a long time. This pressure can lessen blood flow to the affected area, which may lead to tissue damage and tissue death. Pressure ulcers often form on the skin covering bony areas of the body, such as the back, tailbone, hips, buttocks, elbows, heels, and ankles. Patients who cannot get out of bed or change their position, or who always use a wheelchair have an increased risk of ulcers. Pressure ulcers often heal slowly and if not treated can damage tissues deep under the skin, including fat, muscle, and bone. Also called bedsore, decubitus ulcer, and pressure sore. Pressure ulcers are classified in stages by the depth of the tissue damage to the area. The stages range from 1 to 4.The four stages of pressure ulcers are:Stage 1: Redness on the skin that does not blanch (turn white) when pressed. May feel warm to the touch.Stage 2: partial-thickness skin loss. Open sore or blister that may be filled with fluid.Stage 3: Full-thickness skin loss, Subcutaneous tissue (fat) is visible, and May have undermining or tunneling. Stage 4: Full-thickness tissue loss. Muscle, bone, or tendon is exposed. May have significant damage to surrounding tissues.During an interview conducted on 09/15/2025 at 10:14 AM, Resident #126 stated that he/she had a Pressure Ulcer that had worsened now to a stage 4.A Care Plan is a comprehensive document that outlines the specific healthcare needs, goals, and interventions for an individual patient. It serves as a roadmap for healthcare providers, ensuring coordinated and personalized care. A review of Resident #126's Care Plan was conducted on 09/15/2025 at 2:44 PM. The Care Plan stated that the Resident has actual impairment to skin integrity r/t decreased functional mobility as evidenced by pressure injuries to the Sacrum, left ischium, Right Ischium, right heel, right plantar foot, left pinky finger and right upper back/Flank. Resident is at risk for peristomal MASD r/t Colostomy exudate. During an interview conducted on 09/16/25 at 10:33 AM, Resident #126 stated that the nurse did not have Dakins to cleanse his/her sacrum pressure ulcer. During an interview conducted on 09/16/25 at 10:37 AM, License Practica Nurse (LPN) #29 confirmed that she did not use Dakins because it was not available. She stated that the Dakins was in the locked supply room the she did not have access to. She then showed this Surveyor a squirt bottle labeled Skin Integrity Wound Cleanser. She stated that she used that solution instead. A review of Resident #126's Medication Administration Record (MAR) was conducted on 09/16/2025 at 2:54 PM. The MAR showed the following order Cleanse Medial sacrum with NSS [normal saline solution], pat dry, apply Santyl to wound bed, then cover with 1/4 strength Dakin's moist dressing, cover with 4x4 gauze and secure with bordered gauze. every day shift for Wound Tx [treatment] AND as needed every day shift -Order Date09/05/2025 0725.During an interview conducted on 09/17/25 at 6:30 AM, the Director of Nursing (DON) stated that LPN#29 should have access to the supply room but that the Dakins should have been stored in the treatment cart. The DON stated that he would confirm that the facility had Dakins in the facility.During a follow up interview on 09/22/25 at approximately 9:00 AM, the DON stated that he confirmed that the facility does have a supply of Dakins and its location in the treatment cart. The DON further stated he would educate LPN #29 on the location of the Dakins and access to the supply room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews and interviews, it was determined that the facility failed to 1. date and label respiratory therapy equipment according to professional standards of practice and 2. ensure oxygen storage procedures were followed. This was evident for 2 (Resident #14 and #140) out of 5 residents reviewed for Respiratory Care during the annual survey.The findings include:1.On 09/15/25 at 9:31 AM during initial rounds the surveyor observed Resident #14 with oxygen in use via Nasal Cannula tubing. The oxygen tubing was not labeled as to when it was put in use or should be replaced. On 09/15/25 at 9:55 AM the Nurse Staff Educator was notified by the surveyor, and she observed and confirmed the findings. On 09/18/2025 at 8:03 AM a review of Resident #14's clinical record revealed that the resident was admitted with diagnoses including Chronic Respiratory Failure with Hypoxia and End Stage Renal Disease. Further review revealed a physician order written on 08/6/25 for Oxygen at 2 liters per minute via Nasal Cannula as needed for Shortness of Breath. The record failed to reveal an order to change the oxygen tubing. The surveyor also reviewed the facility's policy on Oxygen Administration which was dated 03/14/23 revised on 08/15/25. The policy stated in #5b Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. 09/18/2025 at 10:21 AM in an Interview the Director of Nursing (DON) informed the surveyor that it is the facility's policy to date, label and change oxygen tubing weekly and as needed. He also stated that he was made aware of the surveyor's findings and had started an Inservice training to re-educate the nurses. The DON gave the surveyor a copy of the Inservice training which was initiated on 9/16/25 on changing, dating and labeling of oxygen tubing. 2. During an observation of Resident #140 on 09/17/25 at 12:33 PM, it was noted that he/she was sitting in a reclining chair with an oxygen cylinder standing upright in front of him/her, there was nothing supporting the cylinder. During an observation with the Nurse Staff Educator on 09/17/25 at 12:35 PM she reported that Resident #140 had just returned to his/her room and oxygen was used for transport. She agreed the oxygen cylinder should not be sitting upright and unsupported, they were supposed to put it in a stand. She pulled a rolling stand from behind the curtain in the room of Resident #140, placed the cylinder in the stand and rolled it out of the room. She reported the oxygen cylinder should have been put back in storage and in a holder. During an interview with the Director of Nursing (DON) on 09/19/25 at 6:52 AM the DON advised the oxygen bottle should have been taken out of the Resident's room and put back in storage. During a review of the facility's Oxygen Safety Policy on 09/23/25 at 9:23 AM it was revealed that Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full or empty. The Policy also stated, Protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement.

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	215145	A. Building B. Wing	09/24/2025

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Complete Care at Hyattsville	4922 Lasalle Road Hyattsville, MD 20782

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of employees' files and interviews, it was determined that the facility failed to conduct Performance Reviews at least every 12 months for Geriatric Nursing Assistants (GNAs). This was evident for 1 (GNA #5) of 5 GNAs selected for reviews.The findings include:Performance Reviews are to be completed at least every 12 months to identify in-service education needed to address competencies of GNAs.On 09/23/25 at 10:15 AM the surveyor conducted a review of five GNAs files. The records revealed that GNA #5 was hired in the year 2022 and their annual Performance Review was due on 04/6/25. The most recent Performance Review on record was dated 04/5/24.A further review of the records revealed that the Performance Review was not completed on the due date, and it remained incomplete at the time of the surveyor's review on 09/23/25.On 09/24/25 at 7:26 AM in an interview the Director of Nursing (DON) stated that Performance Reviews for GNAs are conducted annually and as needed. The DON reviewed the records and confirmed the surveyor's findings.Later, on 09/24/25, the DON stated that GNA #5 was at work and gave the surveyor a copy of Staff #5's Performance Review which was completed on 09/24/25 after the surveyor's intervention.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews it was determined that the facility failed to ensure medications were stored properly. This was found to be evident for 1 (Resident #229) out of 4 Residents observed for medication administration during the recertification survey.The findings include:An observation was conducted on 09/17/25 at 8:47 AM of Resident #229's medication administration. This Surveyor observed Registered Nurse (RN) #32 enter the Resident's room carrying 1 cup of water and 1 medication cup of crushed medications in apple sauce. The RN left 1 medication cup of lacosamide 10 MG/ML Oral Solution, 1 medication cup of valporate acid 250 mg/5 ml solution, and 1 medication cup of levETIRAcetam Oral Solution 100 MG/ML solution on top of the unattended medication cart.During an interview conducted on 09/17/25 at 8:57 AM, the RN acknowledged that he should not have left the medications unattended on top of the medication cart. The RN stated that the facility's policy is to store all medications inside of the medication cart when unattended.During an interview conducted on 09/18/25 at 6:30 AM, the Director of Nursing (DON) stated that the Unit Manager notified him of the observation of unattended medications. The DON stated that he began an in-

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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 clinical record review, interviews and review of a complaint, it was determined the facility staff failed to maintain accurate medical records in accordance with accepted professional standards This was evident for 2 (#3, #285) out of 46 sampled residents reviewed during the annual survey.The findings include:1.Resident #3 was admitted to the facility in June 2025 with diagnoses including Chronic Respiratory Failure and Anoxic Brain and is ventilator dependent. On 09/18/25 at 8:16 AM a review of Resident #3's clinical record revealed a physician order written on 06/10/25 stating NPO (nothing by mouth) diet, NPO texture, NPO consistency. The resident received nutrition and medications through a gastrostomy tube (G-tube). Further review of the resident's clinical record revealed a physician order as follows: Atorvastatin Calcium Oral Tablet 20mg. Give 1 tablet by mouth at bedtime for Hyperlipidemia Order Date 06/11/2025. The Medication Administration Record revealed the nurses signed off on the medication being administered by mouth from the date it was ordered to 09/17/25. On 09/18/25 at 09:37 during an interview, the Unit Manager #17 was asked whether the resident received medication by mouth. The manager stated that the resident is NPO and cannot take medications by mouth. The surveyor requested the Unit Manager #17 to review Resident 3's clinical records. Upon review, the Unit Manager confirmed the surveyor's findings and stated, that is a mistake, the resident does not get anything by mouth. On 09/18/25 at 10:12 AM the Director of Nursing (DON), in an interview was notified of the findings and stated that it was a documentation error as the resident was not given the medication by mouth. Later, on 09/18/25, the DON gave the surveyor a copy of the resident's physician order and Medication Administration Record which showed that corrections were made to Resident #3's electronic record on 09/18/25 at 9:55 AM after the surveyor's intervention to reveal Atorvastatin was being administered via G-tube. 2. On 9/23/2025 at 9:32 AM, a review of complaint #2584751, dated 8/8/25 indicated that Resident #285 experienced multiple falls during their stay in the facility. A progress note from 6/7/25, documented a fall where Resident #285 expressed pain when the nurse touched their lower extremity. A pro re nata (PRN) or as needed Tylenol was administered at that time. On 9/23/2025 at 4:28 PM, a subsequent review of Resident #285's June Medication Administration Record (MAR) revealed that the administered PRN Tylenol was not signed as given. On 9/24/2025 at 8:34 AM, in an interview with the Director of Nursing (DON), he stated that during fall incidents the nurses are expected to assess the residents and administer ordered pain medication during fall incidents. The DON was informed of this concern and acknowledged the finding.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews it was determined that the facility failed to ensure residents had access to call bells. This was evident for 2 (#140 & #120) of 46 Residents observed for call bell access during the annual survey. The findings include: 1. During an observation of Resident #140 on 09/16/25 at 11:14 AM it was discovered that the resident's call bell cord was curled into a circle and lying on the floor behind the head of the bed. The Resident was lying in bed and the call bell was not within reach of the resident. During a repeat observation of Resident #140 on 09/17/25 at 12:33 PM it was revealed that he/she was sitting in a reclining chair and the resident's call bell was wrapped in a circle on the floor behind the head of the bed.During an interview and observation with the Director of Nursing (DON) on 09/17/25 at 12:50 PM. The DON advised residents are expected to be within reach of their call bell and agreed the call bell was not in reach of Resident #140. 2. During an observation on 09/17/25 at 9:32 AM Resident #120 was seen lying in bed and the resident's call bell was lying on the floor behind the head of the bed.During a repeat observation on 09/17/25 @ 1:29 PM Resident #120 was seen sitting in a wheelchair beside his/her bed. The call bell was on the opposite side of the resident's bed, near the wall and out of reach for Resident #120.During an interview and observation with Unit Manager #17 on 09/17/25 at 1:31 PM she agreed the call bell was not within reach for Resident #120 and that it should be assessable for the resident.During an interview with the Director of Nursing (DON) on 09/19/25 at 6:52 AM the DON reported that any time a resident is left in a room the staff should provide the residents with their call bell. During a review of the Call Lights: Accessibility and Timely Response Policy on 09/23/25 at 2:32 PM it was discovered that it stated, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. The policy also advised Staff will ensure the call light is within reach of resident and secured, as needed. and The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined that the facility failed to maintain a safe, functional and sanitary environment for residents, staff and visitors. This was evident for 1 of 1 administrative hallways observed during the annual survey.The findings include:On 9/15/25 at 8:05 AM, during the initial tour of the facility, surveyors observed two large bins covered with black plastic bags placed in the administrative hallway between the Director of Nursing's office and the Conference Room. Water was observed dripping from the ceiling into the bins. The black plastic bags contained visible holes, allowing water to collect at the bottom of the bins. Yellow caution tape was tied from a wet floor cone to the handrail, blocking access to that section of the hallway. An orange and white cone was also present. The ceiling tiles above the bins appeared loose and mismatched, and one ceiling tile had a large brown stain.On 9/15/25 at 1:28 PM, this surveyor observed the same bins, caution tape and cones set up in the administrative hallway.In an interview on 9/19/25 at 2:15 PM, the Administrator stated the pipe above the ceiling was not leaking that badly until recently, and the bins were placed to catch condensate. He stated that a contractor had already come out to look at the pipe.In an interview on 9/19/25 at 2:44 PM, the Maintenance Director stated the pipe above the ceiling was corroded and leaking. He stated the pipe had aged out, and that the maintenance staff insulated it, but the leak continued.On 9/23/25 at 8:20 AM, this surveyor requested maintenance logs and work orders related to the leaking pipe in the administrative hallway.In an interview on 9/23/25 at 12:10 PM, the Maintenance Director stated he had contacted an outside vendor (Vendor #25) in August 2025, who inspected the pipe but had not yet provided a proposal for the work.On 9/23/25 at 12:27 PM, a telephone interview was conducted with Vendor #25 regarding the leaking pipe. Vendor #25 confirmed previous visits to the facility on [DATE] and 09/09/25. He stated the repair had to be completed while the environment was occupied which would require more time to complete. Vendor #25 further stated the results of his previous visits would be a proposal, not a work ticket, and that the proposal would be sent in the next day or two.On 9/24/25 at 10:09 AM, the facility provided documentation related to the leaking pipe. Documentation included maintenance logs showing stained ceiling tile replacement in the administrative hallway from June to September 2025, email correspondence with the vendor, and order requests for pipe insulation tape and other materials. However, no documentation was provided to show that the corroded pipe itself had been repaired or replaced.On 9/24/25 at 10:34 AM, this surveyor observed the same setup in the administrative hallway, with water continuing to drip from the ceiling into bins.On 9/24/25 at 12:48 PM, the Administrator provided a document titled Complete Care Hyattsville Timeline of Leaking Pipes. Review of the documentation revealed that the facility identified and was monitoring the leaking pipe but there was no evidence that the corroded pipe had been repaired.At the time of the exit conference on 9/25/25, no additional documentation was provided to show the leaking pipe in the administrative hallway had been repaired.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of employees' files and interviews, it was determined that the facility failed to provide continuing education training of no less than 12 hours per year for Geriatric Nursing Assistants (GNAs). This was evident for 2 (GNA #5 and GNA #22) of 5 GNAs selected for reviews.The findings include:On 09/23/25 at 10:15 AM the surveyor conducted a record review of five GNA files for the period January 1, 2024 to January 1, 2025. The records revealed that GNA #5 who was hired in the year 2022 and GNA #22 who was hired in the year 2015, did not complete their required 12 hours per year Inservice training. On 09/23/25 at 11:24 AM the surveyor interviewed Staff Development Nurse #23 who stated that the facility provides at least 12 hours of Inservice training to GNAs annually through Relias (online training). She further stated that she would check the Relias records to see if the employees completed the training. On 09/24/25 at 2:00 PM during an interview the Director of Nursing (DON) provided the surveyor with GNA #5's and GNA #22's Inservice training for the period January 1, 2024 to January 1, 2025. The records revealed that the employees did not complete 12 hours of Inservice training for that period. The DON confirmed the findings and explained that the computer system did not generate a training schedule for GNA #5 so that employee was unaware of the need to complete the training. Inservice training was scheduled for GNA #22 but the employee did not complete them.