STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 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** 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to follow the wishes of a resident as identified in his/her advanced directive and follow the wishes of the resident's representative for decision making purposes. This was identified for 1 (#5) of 3 residents reviewed during a complaint survey. Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual is not able to make their own decisions. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. The findings include: A review was completed on [DATE] at 9:20 AM secondary to a complaint for Resident #5 submitted by a family member regarding his/her medical status and repeated hospitalization s for dehydration. This record review revealed Resident #5 was admitted with multiple comorbidities including dementia and dysphagia (difficulty swallowing). A review of the residents advanced directive on [DATE] at 12:12 PM revealed that s/he wanted all measures carried out to extend life. On page 5 section B, preferences for terminal condition, #3 was selected try to extend my life for as long as possible using all available interventions that in reasonable medical judgement would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical needs. On page 7, section G effect of stated preference, #2, I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my healthcare provides to follow my stated preferences exactly as written, even if they think that some alternative is better. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the current MOLST (medical orders for life sustaining treatment) on the chart noted that on the back, page 2, #7 for artificially administered fluids and nutrition, 7c was selected; may give fluids for artificial hydration as therapeutic trial but do not give artificially administered nutrition. This MOLST was completed on [DATE] by the facility nurse practitioner and was noted to have been reviewed by the resident's health care agent as named in his/her advanced directive. Resident #5's first hospitalization in 2024 occurred in the beginning of May. S/he was noted with some respiratory distress and increased heart rate. His/her admitting diagnoses included aspiration pneumonia (a lung infection that occurs when food, liquid, vomit, or other material from the mouth or stomach is inhaled into the lungs instead of being swallowed). The code status documented throughout the chart was CPR, full code. A speech evaluation was completed during this hospitalization . This assessment documented that Resident #5 was having a history since 2021 of silent aspirations (when someone accidentally inhales food, liquid, or other material into their airway without realizing it) . The results of this assessment completed ,d+[DATE] stated Resident #5 needed further assessment, patient with baseline moderate dysphagia from prior CVA (cerebrovascular accident, stroke), patient with recurrent aspiration pneumonias, given patient is a silent aspirator from prior MBS (modified barium swallow studies (an X-ray procedure that evaluates how the head and neck work while swallowing, drinking, and chewing), recommended NPO (nothing by mouth), pending FEES (fiberoptic endoscopic evaluation of swallowing, a procedure that assesses how well someone swallows) to further evaluate swallow function and determine safest level of PO (oral) intake. Reported as a high risk for aspiration. Continued review of Resident #5's medical record revealed a change in condition at the end of [DATE]. Resident #5 was noted with shortness of breath and increased respirations. An intravenous line was started with antibiotics and oxygen was administered via nasal cannula; an x-ray was ordered as well in addition to lab work. Twenty-four hours after the initial noted change in condition Resident #5 was transferred to the hospital. His/her admitting diagnosis included acute respiratory failure secondary to aspiration pneumonia, urinary tract infection along with severe hypernatremia. Upon readmission to the facility 9 days later, Resident #5 was continued on intravenous fluids and antibiotics. Another swallow evaluation was completed during this hospitalization . Resident was noted at high risk of aspiration related to ongoing and chronic oropharyngeal dysphagia including known silent aspiration, mentation, being bedbound and dependent on feeding and recurrent pneumonia. A palliative consult was completed during this hospitalization . The goals of care were discussed. The care was discussed with the resident's medical healthcare representative. He stated that 'he wants to do what he can for his [relative] as long as he is able to. He says that he is totally against feeding tube and has had this discussion several times, he does not want to take aways his [relative's] pleasure of eating food. He says that his siblings are aware that patient is not going to be better, but they are doing the best they can for [resident]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on [DATE] at 11:34 AM revealed Resident #5 weighed 160.2 in April and currently in November was weighed at 144.4, a 10% significant weight loss in the noted time frame. On [DATE] at 12:37 NP#1 was interviewed regarding the completed MOLST and Resident #5's status. She stated that on readmissions, they review the MOLST and when there is a change in the resident's status. She stated that she acknowledges knowing that the resident wanted a gastrostomy tube, however the RP/POA was adamant about the resident not getting one and the team had discussed this and assumed that since he was the POA he had the right to say no to these interventions. The facility SW was interviewed on [DATE] at 2:52 PM. She stated that they review the MOLST at every care plan meeting and that the advanced directives should be reviewed as well. The advanced directive for Resident #5 was reviewed at this time. She concurred that the MOLST should be reflective of the advanced directive and page 2, 7c should not be selected as it was in this situation. The collective concerns related to Resident #5 was reviewed with the facility DON at 3:00 PM on [DATE]. She stated that she is contacting the RP and will be getting gastrointestinal consult for the resident. She further reviewed that they wanted this intervention but felt that because the relative was the RP they could not intervene. At 3:30 PM the RP was called related to the placement of the gastrostomy tube. The RP stated that the resident (#5) is not getting a gastrostomy tube, s/he can eat. This surveyor spoke to the RP briefly and only stated that what is in the advanced directive needs to be followed and he agreed. A review on [DATE] at 8:32 AM revealed care plans in place noting Resident #5 at nutritional risk related to impaired swallowing and dysphagia and needing assistance with meals related to aspiration risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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. 31982 Based on record review and interview with staff it was determined the facility staff failed to report an allegation of abuse timely to the State Agency. This was evident for 1 (#8) of 43 residents reviewed during the complaint survey. The findings include: Facility reported incident #MD00205961 was reviewed on 11/25/24 at 12:47 PM. The report revealed that on 5/22/24 at approximately 5:30 PM, Resident (R)#8 reported to Staff #21 a Licensed Practical Nurse, that s/he was hit on the right and left cheek at approximately 3:00 AM by a male and female staff member. The facility reported the allegation of abuse to the state agency on 5/22/24 at 10:30 PM, 5 hours after staff were made aware of the allegation, not within 2 hours as required. The Director of Nursing was made aware of these findings on 11/25/24 at 1:55 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 31982 Based on record review and interview with staff, it was determined the facility staff failed to thoroughly investigate an allegation of resident abuse. This was evident for 1(#6) of 43 resident's reviewed during the complaint survey. The findings include: Facility report #MD00206238 was reviewed on 11/22/24 at 12:08 PM. The report indicated that, on 6/2/24, a family member reported that Resident (R)#6 was struck on the hand by Staff #19 a receptionist on the night of 5/31/24. The report also included that R#6's family member indicated the resident's roommate confirmed it was true. The facility investigation documentation included an assessment of the resident and statements from staff. The facility was unable to conclude that the alleged abuse occurred. However, during their investigation the facility failed to interview R#6's roommate and other residents. During an interview on 11/25/24 at 11:00 AM, Staff #5 an Assistant Director of Nursing, confirmed she investigated R#6's 6/2/24 allegation of abuse. She indicated that her process for investigating included talking to the resident and staff, get interviews, notify the physician, resident representative, police and the Administrator. When asked who she spoke to regarding this particular incident she stated staff, obviously the resident. I don't specifically remember who all I talked to. When asked if she interviewed R#6's roommate she first indicated that the roommate wasn't alert, then indicated s/he was alert but not oriented. Staff #5 then indicated that she didn't remember who she interviewed. She was provided the investigation file and asked if she could find interviews or statements from R#6's roommate or any other residents. After quickly glancing through the folder, she failed to identify any resident interviews and again indicated that she did not remember who she interviewed. The Director of Nursing was made aware of the above findings on 11/25/24 at 12:14 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record review and interview, the facility staff failed to assess residents (resident #22 and #28) after a significant change, a reduction of elopement risk score, causing the residents to be monitored using a elopement deterrent device when it was not necessary. This was evident for 2 out of 43 residents reviewed during a complaint survey. Findings include: 1.Review of resident #22's medical record on 11/22/24 at 11:09 am revealed the resident was admitted to the facility on [DATE] after a stroke left the resident unable to care for him/herself. The stroke caused the resident to require a cane to assist with the resident's balance while walking. The resident was assessed by two physicians on 12/18/15 and 12/30/15 to lack adequate decision-making capacity. Additional review of resident #22's medical record on 11/22/24 at 11:30am revealed that the resident eloped from the facility on 8/3/23. The facility assessed the resident for elopement risk after the 8/3/23 elopement and determined that the resident required a wanderguard. A wanderguard is a monitoring device that is used by a facility to alert staff when a resident with a high elopement risk comes near a facility exit. Continued review of resident #22's medical record on 11/23/24 at 12:30pm revealed that the facility assessed the resident's elopement risk on 2/23/24, 8/12/24 and 11/11/24 and found the resident was a low elopement risk. Review of the resident's wanderguard order revealed that the resident continued to be electronically monitored as if he/she was a high elopement risk. Interview with Social Services' Assistant #7 on 11/25/24 at 8:45am revealed that resident #22 was no longer considered an elopement risk. The surveyor asked why the resident continued to be monitored by a wanderguard if he/she was no longer an elopement risk. Social Services' Assistant #7 stated the assignment of a wanderguard is a clinical decision made by the Director of Nursing and the Unit Manager. Interview with the Assistant Director of Nursing (ADON)/Acting B Unit Manager on 11/25/24 at 9:55am confirmed that Unit Managers and the Director of Nursing (DON) were responsible for determining if a resident is appropriate for a wanderguard. In an interview with the DON on 11/25/24 at 10:10am, the surveyor pointed out that resident #22's elopement risk scores were low and Social Service Assistant #7 confirmed the resident was no longer an elopement risk. The DON stated that he/she would re-assess the resident for wanderguard appropriateness. Interview with the DON on 12/4/24 at 11:00am revealed that resident #22's wanderguard was removed due to the resident no longer being an elopement risk. 2. Review of resident #28's medical record on 11/26/24 at 9:40am revealed the resident was admitted to the facility on [DATE] due to dementia. The resident was assessed by two physicians on 7/25/19 and 8/13/19 to lack adequate decision-making capacity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of resident #28's medical record on 11/26/24 at 10:30am revealed that the resident eloped from the facility on 6/5/22. The facility assessed the resident for elopement risk after the 6/5/22 elopement and determined that the resident required a wanderguard. A wanderguard is a monitoring device that is used by a facility to alert staff when a resident with a high elopement risk comes near a facility exit. Continued review of resident #22's medical record on 11/26/24 at 10:40am revealed that the facility failed to assess the resident's elopement risk after the resident's elopement on 6/5/22. The only elopement risk assessment done was on 3/2/23 and found that the resident was found to have had a low elopement risk. Review of the resident's orders revealed an order for a wanderguard was started in 12/2022 and continued to the date of the surveyor's review of medical records. Interview with the Assistant Director of Nursing (ADON)/Acting C/D Unit Manager on 12/2/24 at 8:30am confirmed that resident #28 was being monitored by a Wanderguard but the ADON was unable to explain why the resident required electronic elopement monitoring. In an interview with the DON on 12/2/24 at 9:00am, the surveyor pointed out that resident #28's elopement risk scores were low, and the ADON/Acting C/D Unit Manager was unable to explain why the resident was being monitored by a wanderguard. The DON confirmed that the resident required re-assessment to determine if the wanderguard was appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 30428 Based on medical record review, observation and interview, it was determined that the facility failed to complete accurate assessments of a resident related to the use of 1. side rails and 2. functional use of extremities on the quarterly and annual minimum data set (MDS). This was determined during the review of side rails for 3 of 3 residents reviewed (#29, #5, #30). The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need The findings include: 1. Review of the medical record for Resident #29 on 11/21/24 at 2:10 PM and observations on multiple occasions including on 11/21, 11/25 and 11/26/24 revealed the presence of 1/2 size side rails on the bed. A review on 11/25/24 at 2:29 PM of Resident #29's MDS, section 'P' restraints revealed for the first section 'A, ' 'not used' was coded for bed rails used for the following assessments: 11/23/23 annual, 12/31/23 quarterly, 4/1/24 quarterly, 7/1/24 quarterly, 7/31/24 quarterly, and 10/29/24 quarterly. Additionally, for the same assessments, that review revealed in section 'GG' functional status 'no impairment'coded in the upper and lower extremity. Observations and nursing documentation for those same time frames contradicted those MDS assessments. MDS staff #1 was interviewed on 11/26/24 at 8:59 AM. S/he was asked the process for completing the MDS. S/he stated that they get their information electronically. This surveyor asked if they ever tour and complete observations of the residents. S/he stated that sometimes they do to confirm information in the electronic medical record. This surveyor reported the concerns in Resident #29's MDS and the errors for the past year related to the presence of the side rails that were documented throughout the chart and the decreased functional status of the residents' extremities. 2. Review of the medical record of Resident # 5 on 11/26/24 at 8:00 AM revealed a physician order entered on 1/8/24 for 1/4 side rails as enablers. Observations of Resident #5 on 11/21/24 at 2:52 PM and continuing throughout the survey revealed the presence of the 1/4 side rails. According to Resident #5's MDS, reviewed on 11/27/24 at 9:00 AM, Section 'P' restraints, 3/7/24 annual, 6/6 quarterly and 9/6 quarterly, 'not used' for bed rails was coded, although there was an order in place 1/8/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident # 30 on 11/26/24 at 8:22 AM revealed a consent for side rails from the family on 4/24/23. Observations on 11/21/24 and 11/26/24 revealed the continued presence of the side rails on Resident #30's bed. Review of the MDS section 'P' on 11/26/24 at 12:00 PM revealed the 6/1 annual and 9/1 quarterly both coded Resident #30 has having 'not used' side rails. This overall review, observation and interview was reviewed with the facility Director of Nursing on 11/26/24 at 3:22 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42886 Based on medical record review and interview, the facility failed to update the resident's care plan after a change in status (Resident # 1). This was evident in 1 of 43 residents reviewed during a complaint survey. The findings include: On 11/21/24 at 1:03 pm, the surveyor reviewed facility reported incident MD00197571 and complaint MD00211157 sent to the Maryland's Department of Health Office of Health Care Quality Long Term Care Unit in 9/2023. The complaint and the facility reported incident expressed concern from resident #1's family regarding the resident's g-tube care. Review of Resident #1's medical records on 11/21/24 at 1:30pm revealed the resident had several incidents when his/her g tube became dislodged, and the resident needed to be transferred to the local hospital for a g tube replacement. The resident was sent out for g tube replacement after the resident's g tube became dislodged on the following dates: 8/20/22, 9/3/23, 7/10/24, and 10/7/24. The facility investigation for each incident determined that facility staff did not cause the g tube to be dislodged. Continued review of resident #1's g tube care plan on 11/22/24 at 7:10am revealed the facility last updated interventions to prevent the dislodging of the resident's g tube in 9/2023. There was no evidence of updates to the g tube care plan after the resident's g tube became dislodged in 7/24 and 10/24. Interview with the C/D Unit Manager on 11/22/24 at 9:05am revealed that he/she normally updated all resident care plans that reside on the C and D unit when there was a change of status. The surveyor confirmed that the C/D Unit Manager failed to update resident #1's g tube care plan after the resident's change of status on 7/2024. Interview with the Nurse Educator on 11/22/24 at 9:30am confirmed that unit managers are responsible for updating resident care plans when there is a change in status. The surveyor informed the Director of Nursing of the failure of the unit manager to update resident #1's care plan on 11/23/24 at 1:00pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to document that care was provided to a resident that was dependent on staff for activities of daily living (ADL). This was evident during the review of a complaint for 2 of 3 (#11 and # 16) residents related to quality of care. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need The findings include: 1. Review of the complaint #MD00180328 revealed concerns related to quality of care and activities of daily living (ADL) and care for incontinence episodes provided in 2021. Resident #11 had since been discharged to the hospital and expired. Review on [DATE] at 10:19 AM revealed multiple days where staff failed to document that care related to bowel and bladder was provided to Resident # 11. From the night shift of [DATE]-[DATE] bowel and bladder care was documented as occurring only 2 times out of a potential 10 times. Review of Resident #11's MDS on[DATE] at 7:30 AM that was completed on [DATE], revealed that Resident #11 was coded in section 'G' functional status, as requiring extensive assistance (requires hands on assistance more than half the time) and in section 'GG' functional abilities Resident #11 was coded as dependent on staff for toileting and toileting transfers. For section 'H' bowel and bladder, Resident #11 was coded as frequently incontinent. Interview on [DATE] at 8:06 AM with GNA#11 revealed that the GNA's are to document on the ADL record every shift what occurred and there should not be any blanks. These concerns were reviewed with the DON on [DATE]. 2. Review of the complaint #MD00200942 on [DATE] at 10:31 AM revealed concerns related to incontinence care provided to a dependent resident. Review at this time for Resident #16 revealed admission for multiple comorbidities including aftercare and infection of hip joint prosthesis and muscle weakness making the resident dependent on staff for ADL care. According to the admission MDS completed on [DATE], Resident #16, in section 'GG' the functional abilities assessment, was noted with impairment in the bilateral lower extremities and was dependent (the helper does all the effort, resident does none of the effort to complete the activities) on staff for toileting. In addition, section 'H,' bowel and bladder noted frequently incontinent for bladder and always incontinent for bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the bowel and bladder record completed for Resident #16 for [DATE], from ,d+[DATE]-, d+[DATE] Resident #16 was documented as having continent and incontinent episodes. However, on the evening shift for ,d+[DATE], ,d+[DATE], ,d+[DATE] and day of ,d+[DATE] there was no documentation of any care provided to the resident. Additionally, no care was documented as provided on the bowel record. From the evening of ,d+[DATE] through the night shifts on ,d+[DATE], a total of 11 shifts, Resident #16 was had no documentation of having any bowel movement. Interview on [DATE] at 8:06 AM with GNA#11 revealed that the GNA's are to document on the ADL record every shift what occurred and there should not be any blanks. The collective concerns were reported to the DON on [DATE] at 11:30 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37296 Based on record review and interviews, it was determined that the facility failed to develop and implement a process to determine if residents with a history of trauma received the appropriate trauma informed care. This was evident for 1 (25) of 3 residents reviewed for trauma informed care. The findings include: A medical record review for Resident #25 on 11/25/24 at 9:30 AM revealed the resident was admitted to the facility on [DATE]. Further review revealed no evidence that an assessment or care plan had been completed to ensure the resident received trauma informed care. On 11/25/24 at 1:13 PM, an interview with Social Worker #7, stated that trauma informed care assessment was done on admission, and annually. Social Worker #7stated that the facility was not administering the trauma informed care assessment at the time s/he was admitted . Social Worker #7 further stated that the trauma informed care assessment was presently incorporated in facility assessments. Further record review revealed that a trauma informed care assessment was completed on 7/24/2023, with implementation of a plan of care addressing the trauma after the investigation of complaint MD00194708.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 30428 Based on medical record review, observation and interview with facility staff, it was determined that the facility failed to assess a resident for the use of side rails when there was a documented change in condition in the resident's functional status. This was evident for 2 of 2 residents observed and reviewed (#26 and #3) during a complaint survey. Bed rails -Adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Synonymous terms are side rails, bed side rails, and safety rails. The findings include: 1. On 11/21/124 at 2:10 PM, the surveyor toured and observed Resident #26 lying in bed, leaning to the right with his/her face against the right-side rail. S/he was making motions with the left arm but could not grasp the side rail. Resident #26 was reviewed and observed secondary to a facility report (FRI) related to Resident #26 having a fractured nasal bone from falling out of bed over the side rails Record review on 11/21/24 at 2:30 revealed an evaluation for the use of side rails that was completed on 2/22/23 and resident representative consent for the use of siderails that was completed on 4/25/23 Continued review of the medical record for Resident #26 revealed that, since the nasal bone fracture on 4/24/23, that there were 4 noted injuries to the resident's body, 2 occurring to the head/face and 5 falls. The nursing assessments completed on 11/21/23 and 7/29/24 in mobility section note under H/I - impairment both sides regarding extremities. Additionally, both assessments document that Resident #26 had quarter side rails for safely and to promote independence with bed mobility. However, when Resident #26 was observed on 11/21/24 at 2:10 there were 1/2 side rails in place and s/he was laying on the right side, 11/25/24 at 1:57 PM, 1/2 side rails in place, laying on the right side of the bed, awake and looking around. Resident did not respond or make eye contact with the surveyor when the surveyor introduced herself. Resident #26 also did not move his/her arms when requested by the surveyor. Resident #26 was observed at 7:03 AM on 11/26 in the center of the bed, at 7:48 AM. Communication was attempted again and s/he did not follow any directions when asked to move his/her arms in specific directions. S/he was observed again at 9:11 AM laying on his/her right side with his/her left hand resting on the side rails. At 11:42 AM on 11/26/24, S/he was still on the right side, with the right arm curled under their chin and the left arm at the side rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's medical record was reviewed. There was nothing in the record related to any attempted interventions that were tried prior to the implementation of the side rails nor was there any information regarding what alternatives were tried, what failed and why. Additionally, when there was a documented decrease in the functionality of the residents' extremities, there was no reassessment and determination of the appropriateness of the side rails. The DON was interviewed on 11/26/24 at approximately 2:30 PM regarding the observations and concerns. She was asked when residents are assessed for the use of side rails. She stated they occurred on admission and when there was a significant change. The documented decrease in Resident #26's functional status was reviewed. There was no follow up re-assessment completed or provided to the survey team that was completed on Resident #26 after the noted change in function that was documented minimally in the nursing assessments in 11/2023. The DON stated that the family had signed the side rail consent at admission and again on 4/25/23, that the side rails were implemented at their request and had remained since. The regulations related to the use of side rails was reviewed at the time and the concerns related to the failure to evaluate for appropriateness and assess for possible alternatives prior to the implementation of side rails based only on the request of the family was reviewed at this time and again during exit. 42886 2. Review of Resident #3's medical records on 12/2/24 at 8:48am revealed change in condition documentation that stated that the resident was observed with a discoloration on the right side of the forehead near the temple on 8/14/24 Provider assessment on 8/14/24 revealed that the discoloration was a result of the resident resting his/her head on the side rail of the bed. Interview with GNA #14 on 12/3/24 at 8:10am confirmed that resident #3 used bed rails on his/her bed to stop him/her from failing out of the bed. Interview with the Director of Nursing (DON) on 12/3/24 at 11:40am revealed that resident #3 was using bed rails when the resident was assessed for bed rail use on 3/27/24 and the assessment recommended that the resident was not to use bed rails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37296 Based on Observation, record review, and interview, it was determined that the facility failed to ensure that residents were free of significant medication errors as evidenced by facility staff failing to administer medications in accordance with professional standards. This was evident for 1 (#17) of 1 resident reviewed for medication administration. The findings include: Medication is to be administered according to the five rights of medication administration: right person, right medication, right route, right dosage, and right time. On 12/2/24 at 11AM, a review of Complaint MD00199498 alledged that Resident #17 medications were not given as prescribed by the physician. A record review of Resident #17's medication administration audit for 11/2023 revealed Resident #17 had been receiving his/her medications late on a regular basis. On 11/23/23, the following medications were administered outside the 1-hour time frame: Tylenol tablet 325 mg by mouth 3 times a day via G-Tube. It was scheduled for administration at 8 AM,12 noon and 8 PM, however this medication was administered outside the 1-hour time frame on 11/1, 11/2, 11/3, 11/5, 11/6 and 11/7/23. Prednisone oral tablet 10 mg one time a day. It was scheduled for administration at 8 AM, however this medication was administered outside the 1-hour time frame on 11/1, 11/2, 11/6 and 11/7/23. Metoprolol Tartrate oral tab 25 mg two times a day via G-Tube. It was scheduled for administration at 8 AM and 8 PM, however this medication was administered outside the 1-hour time frame on 11/1, 11/2, 11/6 and 11/7/23. Finasteride tablet 5 mg give 1 tablet via G-Tube every day. It was scheduled for administration at 9 AM, however this medication was administered outside the 1-hour time frame on 11/1, 11/6 and 11/7/23. On 12/3/24 at 11:30 AM, the findings were discussed with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to ensure that the physician was notified of lab results. This was evident for 1 of 5 lab results reviewed. The findings include: Review of the medical record for Resident # 27 on 12/2/24 at 11:55 AM revealed multiple comorbidities including uncomplicated diabetes of which medication coverage was recently stopped and anemia (when you have low levels of healthy red blood cells to carry oxygen throughout your body). The facility Nurse Practitioner (NP) saw Resident #27 on 10/12/22. During that visit, she reviewed the previous labs that were completed on 9/19/24 and the resident's active diagnosis including leukocytosis (a condition where the white blood cell (WBC) count in the blood is higher than normal) that was noted on the previous lab report with no 'apparent source of infection.' The NP ordered a repeat CBC (complete blood count, a blood test that measures the number and quality of cells in your blood, including red blood cells, white blood cells, and platelets) for the morning of 10/13/22. Surveyor reviewed the paper and electronic medical record. The lab report and results for the 10/13/22 lab were not available on the chart. This surveyor requested the lab report from the DON on 12/2/24. She stated that they use a different lab now but hoped that she would still be able to access the report. At approximately 2:30 PM on 12/2/24, the lab report from 10/13/22 was provided to the survey team. According to the electronic medical record, there was no documentation that any physician was notified or aware of the results. There were 5 documented 'high' flagged results and 5 flagged 'low' results. The facility Medical Director was interviewed on 12/3/24 at 1:20 PM regarding the lack of follow up to the ordered lab. She reported that the lab was reviewed on 10/26/24 when the NP saw the resident again and it was addressed in her note. This surveyor reviewed that there was a 13-day delay in the follow up nd once the labs were reviewed, a repeat CBC was ordered. The medical director was asked about the process of notification for labs, and she said it should be on the chart and the physicians/NPs review and sign them. This surveyor the concern was that this lab was never on the chart and had to be printed by the facility DON on 12/2/24 at 2:00 PM. cross reference F775

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. 30428 Based on medical record review and interview, it was determined that the facility failed to ensure that an ordered lab report was available on the chart for review. This was evident for the review of 1 of 5 labs reviewed during a complaint survey. The findings include: Review of the medical record for Resident # 27 on 12/2/24 at 11:55 AM revealed multiple comorbidities including uncomplicated diabetes of which medication coverage was recently stopped and anemia (when you have low levels of healthy red blood cells to carry oxygen throughout your body). The facility Nurse Practitioner (NP) saw Resident #27 on 10/12/22. During that visit, she reviewed the previous labs that were completed on 9/19/24. The NP ordered a repeat CBC (complete blood count a blood test that measures the number and quality of cells in your blood, including red blood cells, white blood cells, and platelets) for the morning of 10/13/22. Surveyor reviewed the paper and electronic medical record. The lab report and results for the 10/13/22 lab was not available on the chart. This surveyor requested the lab report from the DON on 12/2/24. She stated that they use a different lab now but hoped that she can still access the report. At approximately 2:30 PM on 12/2/24 the lab report from 10/13/22 was provided to the survey team. She confirmed that the lab was not on the chart or available for review in 2022. There were 5 documented 'high' flagged results and 5 flagged 'low' results on that report. The facility Medical Director was interviewed on 12/3/24 at 1:20 PM regarding the lab that was not on the chart for review. She reported that the lab was followed up on, on 10/26/24 when the NP saw the resident again and it is addressed in her note. This surveyor reviewed that that was a 13-day delay and once the labs were reviewed a repeat CBC was ordered. The medical director was asked about the process of notification for labs, and she said it should be on the chart and the physicians/NPs review and sign them. This surveyor reviewed that the concern is that this lab was never on the chart and had to be printed by the facility DON on 12/2/24 at 2:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31982 Based on observation and interview, it was determined the facility staff failed to implement measures to provide warm palatable food to the facility residents. This was evident for 2 of 2 test trays sampled and has the potential to affect all residents who receive meals from the facility kitchen. The findings include: A complaint was reviewed on 12/2/24 at 8:00 AM which included an allegation that the resident's meals were cold. During an interview on 12/2/24 at 10:46 AM, Resident #9 was asked about meal/food temperatures. S/he indicated that the food was not warm sometimes. On 12/2/24 at 12:01 PM, the surveyor requested a test tray during lunch service. At 1:03 PM, the food cart with the test tray was delivered to the C-wing accompanied by Staff #16 the Food Service Manager (FSM). The last tray was delivered from the tray cart to the residents at 1:28 PM and the test tray was sampled immediately afterward. The test tray contained a slice of roast pork, mixed vegetables and rice on a plate covered by a dome lid. There was no base or pellet under the plate. Pellets are metal disks which are heated and placed in bases under dining plates to maintain palatable food temperatures. The food on the plate was slightly warm when sampled. At 1:28 PM, the surveyor also observed 2 lunch trays delivered to the unit from the kitchen on an open rack by Staff #22 a Food Service Worker. When asked how the food on these trays was kept warm, he shrugged. On 12/2/24 at 2:05 PM, the FSM was made aware that the food on the test tray was barely warm, that the plates were directly on the trays with no bases or warming pellets and only a cover to minimize temperature loss. She was also made aware of the 2 trays that were delivered on an open rack by Staff #22. On 12/3/24 at 8:25 AM, the surveyor observed nursing staff distributing breakfast trays from another open shelf rack on C-Wing. 5 breakfast trays were on the rack. 5 additional plate covers were stacked on the bottom of a drink cart. There were no enclosed carts present on C Wing. During an interview on 12/3/24 at 9:14 AM, the Dietician (Staff #17) was asked how the facility ensured the resident's meals were served at palatable temperatures. She indicated they used heated plates. She indicated that they had pellets, but it was her understanding there were not enough, and she thought there was no pellet warmer. She added that the nurses don't have enough time to reheat each tray, and repeated that the facility did not have enough pellets. She was made aware of the above findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In another interview on 12/3/24 at 9:57 AM, the FSM was asked why the facility was not using hot pellets to keep meals warm. She indicated they were in the process of ordering the machine to activate the pellets. When asked how long it had been since the facility used heated pellets; she indicated that she did not know. She was asked how she ensured that the serving temperature of the food was palatable. She stated: I follow the trays down and check a test tray just like you did. She indicated that she did not know if a pellet warmer had been ordered and would have to check with the Administrator. On 12/3/24 at 12:45 PM The surveyor requested another test tray during lunch service. At 1:09 PM, a closed cart containing the test tray left the kitchen. The FSM remained with the surveyor during tray distribution. The staff delivered the last tray from the cart to the residents at 1:20 PM. The surveyor immediately took the test tray to the conference room and measured the temperature of the food items using a food thermometer that was checked and calibrated at 12:40 PM the same day. A chicken thigh measured 85 degrees Fahrenheit (F), corn was 98 F, and the roasted potatoes were 82 F. The FSM who was present was shown and responded uh-huh to each temperature measured. The above concerns were reviewed with the Administrator and Director of Nursing on 12/3/24 at 2:25 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 31982 Based on interviews, and record review, it was determined the facility staff failed to honor resident food preferences. This was evident for 1(#9) of 43 residents reviewed during the complaint survey. The findings include: A complaint alleging that residents food preferences were not honored by the facility staff was reviewed on 12/2/24 at 9:53 AM. The complainant indicated that Resident (R)#9 did not like shrimp, so when shrimp was served, R#9 did not eat. In an interview on 12/2/24 at 12:01 PM, Staff #16 the Food Service Manager (FSM) was asked to describe the process for honoring the residents' food preferences. She explained that the actual dislikes were not listed on the resident meal ticket, that preferences were entered into the system, the alternative food item would print on the resident's meal ticket for each meal that the disliked item is served, and staff would provide the alternative rather than the disliked item. She indicated either she or the Dietician were responsible for identifying the residents' dislikes. She was asked to provide the surveyor with a list of food dislikes for R#9. After looking in the electronic system, the FSM indicated that no dislikes were listed for R#9. When asked who spoke to R#9 about his/her food dislikes/preferences, she indicated either herself or the Dietician but was not sure which one. During an interview on 12/2/24 at 12:17 PM, R#9 was asked if s/he recalled speaking to someone regarding food preferences, it was a long time ago and s/he could not recall who s/he spoke to. When asked about dislikes, R#9 stated s/he did not like shrimp, then confirmed that s/he was given shrimp. She indicated that staff will sometimes call down to get an alternative. S/he indicated that Staff #15 a Geriatric Nursing Assistant (GNA) called the kitchen several times to let them know and to get him/her something else to eat but they continue to send shrimp. Staff #15 was interviewed on 12/3/24 at 8:00 AM. She indicated she was aware of R#9's dislike and preference to not have shrimp. She indicated it happened repeatedly, and she had contacted the kitchen to get R#9 something else. She indicated that she also reported to the kitchen that R#9 does not eat shrimp but could not recall who she spoke to. The most recent Quarterly Nutrition Assessment for R#9 was reviewed on 12/3/24 at 7:30 AM. The assessment was completed by Staff #17 the Dietician on 10/24/24. It did not identify food preferences or dislikes. In an interview on 12/3/24 at 9:14 AM, Staff #17 indicated both she and the FSM will conduct initial visits with residents and get their food preferences. She documented preferences in her assessment and the FSM documented them on a form, then put it into the system. She indicated that she reviewed food preferences with the residents during their quarterly and annual assessments. She was made aware of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record review and interview, the facility administration failed to provide a surveyor with QA and risk management records after an incident when a resident (resident #41) sustained injury from being burned by a hot liquid. This was evident for 1 out of 43 residents reviewed during a complaint survey. Findings include: On 12/2/24 at 10:45 am, the surveyor reviewed complaint MD00176117 sent to the Maryland's Department of Health Office of Health Care Quality Long Term Care Unit in 12/2021. The complaint expressed concern from resident #41's family regarding the facility's failure to monitor the resident, causing the resident to be burned by hot liquids. Review of Resident #41's medical records, on 12/2/24 at 11:30am, revealed the resident was admitted to the facility on [DATE] due to complications involving Multiple Sclerosis (MS). The resident required extensive assistance and modified drinkware/utensils when eating due to numbness in hands and fingers as a result of MS. Change in condition documentation on 12/4/21 revealed that the resident sustained burns on his/her thighs and chest after he/she spilled a hot drink on themselves. Interview with the Nurse Educator/Former Unit B Manager on 12/3/24 at 1:00pm confirmed that resident #41 sustained burns from spilling a cup of hot chocolate on his/her thighs and chest. Nurse Educator/Former Unit B Manager stated that the hot chocolate was given to the resident by a family member without facility staff being aware and that the family member provided the resident with a hot liquid without their modified drinkware/utensils. The Nurse Educator/Former Unit B Manager confirmed that he/she assisted in completing the risk management investigation and QA activities after the resident's 12/4/21 burn incident. Interview with the Director of Nursing (DON) and the Executive Director on 12/3/24 at 2:30pm revealed that the facility was unable to locate a root cause analysis, risk management and/or QA activities for resident #41's 12/4/21 burn incident. The surveyor asked the Executive Director and the DON if the facility would have conducted a root cause analysis and other risk management/QA activities after the resident's 12/4/21 burn incident. Both the DON and the Executive Director confirmed that the facility would have conducted a root cause analysis and any other risk assessment activities to determine if the resident's 12/4/21 burn incident was a potential problem for other residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record review and interview, the facility administration failed to maintain QA and risk management records for five years after a resident was discharged from the facility. This was evident for 1 (resident #41) out of 43 residents reviewed during a complaint survey. Findings include: On 12/2/24 at 10:45 am, the surveyor reviewed complaint MD00176117 sent to the Maryland's Department of Health Office of Health Care Quality Long Term Care Unit in 12/2021. The complaint expressed concern from resident #41's family regarding the facility's failure to monitor the resident causing the resident to be burned by hot liquids. Review of Resident #41's medical records on 12/2/24 at 11:30am revealed the resident was admitted to the facility on [DATE] due to complications involving Multiple Sclerosis (MS). The resident required extensive assistance and modified drinkware/utensils when eating due to numbness in hands and fingers as a result of MS. Change in condition documentation on 12/4/21 revealed that the resident sustained burns on his/her thighs and chest after he/she spilled a hot drink on themselves. Interview with the Nurse Educator/Former Unit B Manager on 12/3/24 at 1:00pm confirmed that resident #41 sustained burns from spilling a cup of hot chocolate on his/her thighs and chest. Nurse Educator/Former Unit B Manager stated that the hot chocolate was given to the resident by a family member without facility staff being aware that the family member provided the resident with a hot liquid without his/her modified drinkware/utensils. The Nurse Educator/Former Unit B Manager confirmed that he/she assisted in completing the risk management investigation and QA activities after the resident's 12/4/21 burn incident. Interview with the Director of Nursing (DON) and the Executive Director on 12/3/24 at 2:30pm revealed that the facility was unable to locate a root cause analysis, risk management and/or QA activities for resident #41's 12/4/21 burn incident. The surveyor asked the Executive Director and the DON if the facility would have conducted a root cause analysis and other risk management/QA activities after the resident's 12/4/21 burn incident. Both the DON and the Executive Director confirmed that the facility would have conducted a root cause analysis and any other risk assessment activities to determine if the resident's 12/4/21 burn incident was a potential problem for other residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 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** 40927 Based on observation and interview, it was determined that facility staff failed to removed their personal protective equipment based on the Centers for Disease Control's guidelines during a COVID 19 outbreak. This was evident for 1 of 1 COVID 19 unit. The findings include: Personal Protective Equipment (PPE) - gloves, gowns, eye protection (safety glasses or shield), and mask. Center for Disease Control (CDC) 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in a Healthcare Settings that was last updated 9/2024 states that for a resident on contact isolation, staff should remove their gloves and gown before exiting the resident's room. www.cdc.gov An observation of the designated COVID 19 unit on 11/21/24 at 8:42 AM, the hallway was cluttered on both sides with several items to include isolation bins sitting outside the resident's rooms and open trashcans. The isolation bins had drawers that were left open across from room [ROOM NUMBER]. The isolation bin outside of room [ROOM NUMBER] had a bed pan sitting on top and there were 2 urine caps inside the bed pan. Beside the isolation bin, sitting on the floor was a bed pan with a toilet plunger sitting inside of it. On 11/21/24 at 8:53 AM, Geriatric Nursing Assistant (GNA) #23 came out of a resident's room with his gown, gloves, mask, and shield on. He removed the gown and gloves in the hallway outside the room and threw it in the trashcan outside the room door. He started walking down the hallway towards the nursing station. An interview was conducted with GNA #23 directly following this observation. When asked what the process was for putting on and taking off his personal protective equipment (PPE), he stated he was supposed to put the PPE on while in the resident's room and take it off once he was outside the resident's room. He stated he was supposed to remove everything except for the shield. He had not removed his mask at the time of the interview and stated he was going to throw it away in a trashcan down the hallway near the food cart. He had not been observed to sanitize his hands since removing the PPE and stated he had planned to wash his hands in the soiled utility room near the nurses' station. During the interview, GNA #23 was observed touching his mask and face shield multiple times after removing his PPE and not sanitizing his hands. During an observation of GNA #23 on 11/21/24 at 9:00 AM, he took 2 food trays, that were for 2 different residents into a room at the same time. When he came out of the room, he removed his gown and gloves standing outside the room. He did not remove his mask and went down the hallway to use hand sanitizer close to the food cart. An interview was conducted with GNA #23 directly following the interview. He stated that he took both trays into the room and set up one resident and then the other resident. He failed to change his gloves or gown while in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of GNA #23 on 11/21/24 at 9:11 AM, he came out of room [ROOM NUMBER], removed his PPE and proceeded to carry the PPE down the hallway to room [ROOM NUMBER] and throw it in the trashcan outside the room. GNA #23 was observed on 11/21/24 at approx. 9:12 AM coming out of room [ROOM NUMBER], removed his PPE to include the mask and then apply another masked without sanitizing his hands. An interview with the Unit Manager #24 on 11/21/24 at 12:44 PM revealed taht staff were to put on their PPE before entering the resident's room and then before leaving the resident's room, they should remove the PPE and throw it away in the trashcan in the room. She reported they should sanitize their hands right away. She reported that staff were to reuse their mask and face shield, but gloves and gowns should be changed each time. When asked how she monitored staff to ensure they were following appropriate infection control process, she stated that all staff were supposed to say something to a staff member if they were not following the process. She was made aware that there was 2 other GNAs and 2 nurses in the hallway while the observations were made. She stated the staff should have said something to GNA #23. When asked if it was appropriate to take both food trays into the residents' room at one time, she stated it was not. She stated that there was no way to change the isolation gown in the room and that should have been changed between the residents. On 11/21/24 at 1:42 PM, the Infection Control Preventionist (ICP) was interviewed. He reported that the last training for PPE was about 3 months ago. He reported that, since the onset of the COVID 19 outbreak on 11/12/24, they had not provided training for the use of PPE to staff. Reviewed the observations with him and he reported that PPE should be removed and placed in a plastic bag to be discarded in the trash can after leaving the resident's room. Reviewed the Centers for Disease Control's guidance for contact isolation that PPE should be removed and discarded prior to leaving the resident's room. He stated that they were following the guidance of a tact team that came in for a review. However, he was unable to provide a copy of these recommendations before the exit of the survey team. Reviewed the concerns with staff taking both resident's food trays into the room at one time. He stated that was not a good infection control practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40927 Based on observation and interview, it was determined that the facility failed to maintain a safe environment for their residents. This was evident for 3 (Unit A, B, D) of 4 nursing units. The findings include: 1. On 11/21/24 at 8:42 AM, the surveyor toured the A wing unit. The hallway that contained rooms 101 -120 was cluttered on both sides of the hallway leaving less than 3 feet to maneuver down the hallway. At the end of the hallway was an empty wheelchair (w/c) sitting in front of the exit door beside room [ROOM NUMBER]. Also lined up on the left side of the hallway were 2 w/c, dining room chair, isolation cart, trashcan, and a bed pan with a toilet plunger was on the left side of the hallway. On the right side was an isolation cart. Two beds and a dresser were in hallway between 115 and 116 and between rooms [ROOM NUMBERS] was two beds. Bedside tables, isolation cart, and a dresser were between rooms [ROOM NUMBERS]. An interview with the Unit Manager for Unit 2 on 11/21/24 at 9:28 AM, while she was standing outside room [ROOM NUMBER], revealed she had not addressed the clutter in the hallway. She reported that she was not sure what they would do if there was an emergency and residents needed to leave the building. An interview with the Nursing Home Administrator (NHA) on 11/21/24 at 9:41 AM revealed that he had been made aware of the issue on Unit A after surveyor intervention. He reported that the maintenance staff had moved the furniture from a few rooms to do maintenance and that they had removed the furniture from the hallway. 30428 2. The following observations were made during the complaint survey on the 'B' wing. Tour starting at 11/21/24 at 8:45 AM noted that at the end of hallway of the C wing and entrance to the B wing, there was 3 Geri chairs sitting, with 2 chairs. In the chairs were a seat cushion, heal booties and foot boot. Entrance to the 'B' hallway, surveyor found 8 wheelchairs, 2 chairs and 1 resident lying awake in a Geri Chair against the left wall, the handrail inaccessible the full length of the hallway. The hallway had a crowded appearance and feel. There were also 2 medications carts, the breakfast cart and a drink cart to serve the residents along the hall that staff and residents needed to navigate to make it down the path of the hallway. The DON was notified at 9:07 AM of the concerns found on all the hallways by the survey team. Residents had been observed independently mobilizing around the facility using the handrails as guides. However, with the plethora of equipment in the hallways, not all the handrails were easily accessible, nor were the hallways easily accessible especially in an emergency. The DON's attention was also brought to the number of residents that were observed rolling up and down the halls that used the hand rails for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215151	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Laplata LLC	1 Magnolia Drive Laplata, MD 20646

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated that all that equipment was there because staff was getting residents up for the day. Again, the concern that the handrails were not accessible was reviewed. On 11/22/24 at 12:10 PM, the 'B' hallway was toured. These observations revealed 5 wheelchairs along the left wall and 2 residents up in Geri chairs. During these observations, this surveyor was asked to move as environmental services was cleaning the floors and for him to continue this surveyor need to step into a resident room, as there was no room between the equipment, medications carts etc. and the employee cleaning the floors. On 11/27/24 at 7:07 AM, surveyor observed 6 wheelchairs, 3 Geri chairs and 1 standardized chair sitting on the left side of the hall. The total observations were reviewed with the DON. She asked on 12/2/24 if the halls were better. The survey team reported that according to our documented observations, there was still a plethora of items left in the hallways. She stated that she would follow up. 42886 3. On 11/21/24 at 8:45am, the surveyor observed the D unit hallway many pieces of furniture in the hallway obstructing residents use of the handrails. The furniture in the D unit hallway included: 3 reclining chairs, 4 wheelchairs, and two dining room chairs. Interview with the C/D Unit Manager on 11/21/24 at 9:00am revealed that the clutter in the D Unit hallway is a result of the resident rooms not having enough space for GNAs to provide care to the residents in the morning. The surveyor told the C/D Unit Manager that the hallway clutter was a concern for resident safety. The surveyor continued to see the resident bedroom furniture cluttering the unit hallway from 11/21/24, 11/22/24, 11/25/24, 11/26/24, and 12/2/24.