

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Laplata LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**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 required information was sent to the hospital when the resident was transferred. This was found to be evident for 1 (Resident # 1) out of 2 resident complaints.</p> <p>The findings include:</p> <p>On 4/10/25, a review of Resident #1's closed medical record revealed that Resident #1 was admitted to the facility on [DATE] and was transferred to the hospital on 3/24/25.</p> <p>Review of the medical record failed to reveal documentation to indicate the resident's care plan goals were sent to the hospital when the resident was transferred on 3/24/25.</p> <p>No documentation was found to indicate the education provided included review of the specific information required to be sent to the receiving facility at the time of transfer.</p> <p>In an interview with the Director of Nurses (DON) on 4/10/25 at approximately 11:25 AM, the DON stated that Resident #1 was sent back to the hospital to be evaluated for wandering into other resident rooms, being aggressive, and being combative. The DON also stated that the facility hospital liaison informed the hospital that Resident #1 would be returning. The DON stated that he was not sent back to the hospital under an involuntarily discharge. The DON stated that Resident #1 had not been assessed by any facility physician since being admitted on [DATE].</p> <p>In an interview with the facility hospital liaison, staff member #9, on 04/10/25 at 11:34 AM, the facility hospital liaison stated that s/he reviewed Resident #1 medical records, that were provided by the hospital and cleared Resident #1 to be admitted on the facility on 03/21/25. The facility hospital liaison stated that s/he received an email from the DON on 03/23/25 at 11:30 AM that indicated Resident #1 was not for this building and needs a facility with a locked unit. The facility hospital liaison stated that s/he did not read the Sunday email from the DON because s/he does not work on Sunday and the Clinical Nurse Consultant was out of the country on vacation. The facility hospital liaison stated s/he did read the email after 12 noon on Sunday and then s/he spoke to the charge nurse overseeing Resident #1's care on Sunday and was informed Resident #1 was antsy. The facility hospital liaison then stated s/he was in contact with the hospital social worker and informed then Resident #1 was being sent back to the hospital not by 911. The facility hospital liaison stated that Resident #1 was not displaying behaviors at the hospital before being admitted to the facility.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 04/10/25 at 11:56 AM, the DON confirmed that Resident #1 was not seen by the facility psychiatric services before being sent to the hospital on [DATE].</p> <p>In an interview with the hospital social worker (staff member #11) on 04/10/25 at 1:06 PM, the hospital social worker stated that Resident #1 was still residing at the hospital since being discharge by the facility on 03/24/25 and that the facility DON informed the hospital staff that Resident #1's return was not an option. The hospital social worker stated that facility staff did not send any type of paperwork or his/her belongings with Resident #1 to the hospital on [DATE].</p> <p>In an interview with the hospital social worker #2 (staff member #12) on 04/10/25 at 1:32 PM, the hospital social worker #2 stated that s/he spoke with the facility hospital liaison and was told that heads up, Resident #1 might be coming back to the hospital and that the DON was unable to accept Resident #1 at the facility. Hospital social worker #2 stated that the facility did not receive any paper work nor a bed hold for Resident #1 when Resident #1 was sent back to the ER on [DATE].</p> <p>In an interview with the facility medical director on 04/10/25 at 3 PM, the medical director stated that s/he did not have any input into sending Resident #1 back to the ER on [DATE].</p> <p>In an interview with the facility DON on 04/10/25 at 3:45 PM with the ADON, the DON stated that s/he was the facility staff person who made the decision to send Resident #1 back to the hospital on [DATE].</p> <p>In an interview with the facility social worker (staff member #6) on 04/10/25 at 3:40 PM, the facility social worker stated that s/he was not involved with Resident #1's discharge to the hospital on [DATE]. The facility social worker also stated that s/he did not pursue calling other facilities to help relocate Resident #1 on 03/24/25.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**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 provide a notice of discharge to Resident #1 before or during before being sent back to the hospital on [DATE]. This was found to be evident for 1 (Resident # 1) out of 2 resident complaints.</p> <p>The findings include:</p> <p>On 4/10/25, a review of Resident #1's closed medical record revealed that Resident #1 was admitted to the facility on [DATE] and was transferred to the hospital on 3/24/25.</p> <p>Review of the medical record failed to reveal documentation to indicate the resident's care plan goals were sent to the hospital when the resident was transferred on 3/24/25.</p> <p>No documentation was found to indicate the education provided included review of the specific information required to be sent to the receiving facility at the time of transfer.</p> <p>In an interview with the Director of Nurses (DON) on 4/10/25 at approximately 11:25 AM, the DON stated that Resident #1 was sent back to the hospital to be evaluated for wandering into other resident rooms, being aggressive, and being combative. The DON also stated that the facility hospital liaison informed the hospital that Resident #1 would be returning. The DON stated that he was not sent back to the hospital under an involuntary discharge. The DON stated that Resident #1 had not been assessed by any facility physician since being admitted on [DATE].</p> <p>In an interview with the facility hospital liaison, staff member #9, on 04/10/25 at 11:34 AM, the facility hospital liaison stated that s/he reviewed Resident #1 medical records, that were provided by the hospital and cleared Resident #1 to be admitted on the facility on 03/21/25. The facility hospital liaison stated that s/he received an email from the DON on 03/23/25 at 11:30 AM that indicated Resident #1 was not for this building and needs a facility with a locked unit. The facility hospital liaison stated that s/he did not read the Sunday email from the DON because s/he does not work on Sunday and the Clinical Nurse Consultant was out of the country on vacation. The facility hospital liaison stated s/he did read the email after 12 noon on Sunday and then s/he spoke to the charge nurse overseeing Resident #1's care on Sunday and was informed Resident #1 was antsy. The facility hospital liaison then stated s/he was in contact with the hospital social worker and informed then Resident #1 was being sent back to the hospital not by 911. The facility hospital liaison stated that Resident #1 was not displaying behaviors at the hospital before being admitted to the facility.</p> <p>In an interview with the DON on 04/10/25 at 11:56 AM, the DON confirmed that Resident #1 was not seen by the facility psychiatric services before being sent to the hospital on [DATE].</p> <p>In an interview with the hospital social worker (staff member #11) on 04/10/25 at 1:06 PM, the hospital social worker stated that Resident #1 was still residing at the hospital since being discharge by the facility on 03/24/25 and that the facility DON informed the hospital staff that Resident #1's return was not an option. The hospital social worker stated that facility staff did not send any type of paperwork or his/her belongings with Resident #1 to the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the hospital social worker #2 (staff member #12) on 04/10/25 at 1:32 PM, the hospital social worker #2 stated that s/he spoke with the facility hospital liaison and was told that heads up, Resident #1 might be coming back to the hospital and that the DON was unable to accept Resident #1 at the facility. Hospital social worker #2 stated that the facility did not receive any paper work nor a bed hold for Resident #1 when Resident #1 was sent back to the ER on [DATE].</p> <p>In an interview with the facility medical director on 04/10/25 at 3 PM, the medical director stated that s/he did not have any input into sending Resident #1 back to the ER on [DATE].</p> <p>In an interview with the facility DON on 04/10/25 at 3:45 PM with the ADON, the DON stated that s/he was the facility staff person who made the decision to send Resident #1 back to the hospital on [DATE].</p>

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**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 provide documentation to Resident #1 or the responsible party before being transferred to the hospital on [DATE]. This was found to be evident for 1 (Resident # 1) out of 2 resident complaints.</p> <p>The findings include:</p> <p>On 4/10/25, a review of Resident #1's closed medical record revealed that Resident #1 was admitted to the facility on [DATE] and was transferred to the hospital on 3/24/25.</p> <p>Review of the medical record failed to reveal documentation to indicate the resident's care plan goals were sent to the hospital when the resident was transferred on 3/24/25.</p> <p>No documentation was found to indicate the education provided included review of the specific information required to be sent to the receiving facility at the time of transfer.</p> <p>In an interview with the Director of Nurses (DON) on 4/10/25 at approximately 11:25 AM, the DON stated that Resident #1 was sent back to the hospital to be evaluated for wandering into other resident rooms, being aggressive, and being combative. The DON also stated that the facility hospital liaison informed the hospital that Resident #1 would be returning. The DON stated that he was not sent back to the hospital under an involuntary discharge. The DON stated that Resident #1 had not been assessed by any facility physician since being admitted on [DATE].</p> <p>In an interview with the facility hospital liaison, staff member #9, on 04/10/25 at 11:34 AM, the facility hospital liaison stated that s/he reviewed Resident #1 medical records, that were provided by the hospital and cleared Resident #1 to be admitted on the facility on 03/21/25. The facility hospital liaison stated that s/he received an email from the DON on 03/23/25 at 11:30 AM that indicated Resident #1 was not for this building and needs a facility with a locked unit. The facility hospital liaison stated that s/he did not read the Sunday email from the DON because s/he does not work on Sunday and the Clinical Nurse Consultant was out of the country on vacation. The facility hospital liaison stated s/he did read the email after 12 noon on Sunday and then s/he spoke to the charge nurse overseeing Resident #1's care on Sunday and was informed Resident #1 was antsy. The facility hospital liaison then stated s/he was in contact with the hospital social worker and informed then Resident #1 was being sent back to the hospital not by 911. The facility hospital liaison stated that Resident #1 was not displaying behaviors at the hospital before being admitted to the facility.</p> <p>In an interview with the DON on 04/10/25 at 11:56 AM, the DON confirmed that Resident #1 was not seen by the facility psychiatric services before being sent to the hospital on [DATE].</p> <p>In an interview with the hospital social worker (staff member #11) on 04/10/25 at 1:06 PM, the hospital social worker stated that Resident #1 was still residing at the hospital since being discharge by the facility on 03/24/25 and that the facility DON informed the hospital staff that Resident #1's return was not an option. The hospital social worker stated that facility staff did not send any type of paperwork or his/her belongings with Resident #1 to the hospital on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the hospital social worker #2 (staff member #12) on 04/10/25 at 1:32 PM, the hospital social worker #2 stated that s/he spoke with the facility hospital liaison and was told that heads up, Resident #1 might be coming back to the hospital and that the DON was unable to accept Resident #1 at the facility. Hospital social worker #2 stated that the facility did not receive any paper work nor a bed hold for Resident #1 when Resident #1 was sent back to the ER on [DATE].</p> <p>In an interview with the facility medical director on 04/10/25 at 3 PM, the medical director stated that s/he did not have any input into sending Resident #1 back to the ER on [DATE].</p> <p>In an interview with the facility DON on 04/10/25 at 3:45 PM with the ADON, the DON stated that s/he was the facility staff person who made the decision to send Resident #1 back to the hospital on [DATE].</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**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 provide a bed hold notice to Resident #1 or the responsible party before being transferred to the hospital on [DATE]. This was found to be evident for 1 (Resident # 1) out of 2 resident reviewed during a complaint survey.</p> <p>The findings include:</p> <p>On 4/10/25, a review of Resident #1's closed medical record revealed that Resident #1 was admitted to the facility on [DATE] and was transferred to the hospital on 3/24/25.</p> <p>Review of the medical record failed to reveal documentation to indicate the resident's care plan goals were sent to the hospital when the resident was transferred on 3/24/25.</p> <p>No documentation was found to indicate the education provided included review of the specific information required to be sent to the receiving facility at the time of transfer.</p> <p>In an interview with the Director of Nurses (DON) on 4/10/25 at approximately 11:25 AM, the DON stated that Resident #1 was sent back to the hospital to be evaluated for wandering into other resident rooms, being aggressive, and being combative. The DON also stated that the facility hospital liaison informed the hospital that Resident #1 would be returning. The DON stated that he was not sent back to the hospital under an involuntary discharge. The DON stated that Resident #1 had not been assessed by any facility physician since being admitted on [DATE].</p> <p>In an interview with the facility hospital liaison, staff member #9, on 04/10/25 at 11:34 AM, the facility hospital liaison stated that s/he reviewed Resident #1 medical records, that were provided by the hospital and cleared Resident #1 to be admitted on the facility on 03/21/25. The facility hospital liaison stated that s/he received an email from the DON on 03/23/25 at 11:30 AM that indicated Resident #1 was not for this building and needs a facility with a locked unit. The facility hospital liaison stated that s/he did not read the Sunday email from the DON because s/he does not work on Sunday and the Clinical Nurse Consultant was out of the country on vacation. The facility hospital liaison stated s/he did read the email after 12 noon on Sunday and then s/he spoke to the charge nurse overseeing Resident #1's care on Sunday and was informed Resident #1 was antsy. The facility hospital liaison then stated s/he was in contact with the hospital social worker and informed then Resident #1 was being sent back to the hospital not by 911. The facility hospital liaison stated that Resident #1 was not displaying behaviors at the hospital before being admitted to the facility.</p> <p>In an interview with the DON on 04/10/25 at 11:56 AM, the DON confirmed that Resident #1 was not seen by the facility psychiatric services before being sent to the hospital on [DATE].</p> <p>In an interview with the hospital social worker (staff member #11) on 04/10/25 at 1:06 PM, the hospital social worker stated that Resident #1 was still residing at the hospital since being discharge by the facility on 03/24/25 and that the facility DON informed the hospital staff that Resident #1's return was not an option. The hospital social worker stated that facility staff did not send any type of paperwork or his/her belongings with Resident #1 to the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the hospital social worker #2 (staff member #12) on 04/10/25 at 1:32 PM, the hospital social worker #2 stated that s/he spoke with the facility hospital liaison and was told that heads up, Resident #1 might be coming back to the hospital and that the DON was unable to accept Resident #1 at the facility. Hospital social worker #2 stated that the facility did not receive any paper work nor a bed hold for Resident #1 when Resident #1 was sent back to the ER on [DATE].</p> <p>In an interview with the facility medical director on 04/10/25 at 3 PM, the medical director stated that s/he did not have any input into sending Resident #1 back to the ER on [DATE].</p> <p>In an interview with the facility DON on 04/10/25 at 3:45 PM with the ADON, the DON stated that s/he was the facility staff person who made the decision to send Resident #1 back to the hospital on [DATE].</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**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 issue an involuntary discharge to Resident #1 before being transferred to the hospital on [DATE]. This failure did not allow Resident #1 to become aware of all his/her legal rights as a resident in a Long Term Care Facility. This was found to be evident for 1 (Resident # 1) out of 2 resident reviewed during a complaint survey.</p> <p>The findings include:</p> <p>On 4/10/25, a review of Resident #1's closed medical record revealed that Resident #1 was admitted to the facility on [DATE] and was transferred to the hospital on 3/24/25.</p> <p>Review of the medical record failed to reveal documentation to indicate the resident's care plan goals were sent to the hospital when the resident was transferred on 3/24/25.</p> <p>No documentation was found to indicate the education provided included review of the specific information required to be sent to the receiving facility at the time of transfer.</p> <p>In an interview with the Director of Nurses (DON) on 4/10/25 at approximately 11:25 AM, the DON stated that Resident #1 was sent back to the hospital to be evaluated for wandering into other resident rooms, being aggressive, and being combative. The DON also stated that the facility hospital liaison informed the hospital that Resident #1 would be returning. The DON stated that he was not sent back to the hospital under an involuntarily discharge. The DON stated that Resident #1 had not been assessed by any facility physician since being admitted on [DATE].</p> <p>In an interview with the facility hospital liaison, staff member #9, on 04/10/25 at 11:34 AM, the facility hospital liaison stated that s/he reviewed Resident #1 medical records, that were provided by the hospital and cleared Resident #1 to be admitted on the facility on 03/21/25. The facility hospital liaison stated that s/he received an email from the DON on 03/23/25 at 11:30 AM that indicated Resident #1 was not for this building and needs a facility with a locked unit. The facility hospital liaison stated that s/he did not read the Sunday email from the DON because s/he does not work on Sunday and the Clinical Nurse Consultant was out of the country on vacation. The facility hospital liaison stated s/he did read the email after 12 noon on Sunday and then s/he spoke to the charge nurse overseeing Resident #1's care on Sunday and was informed Resident #1 was antsy. The facility hospital liaison then stated s/he was in contact with the hospital social worker and informed then Resident #1 was being sent back to the hospital not by 911. The facility hospital liaison stated that Resident #1 was not displaying behaviors at the hospital before being admitted to the facility.</p> <p>In an interview with the DON on 04/10/25 at 11:56 AM, the DON confirmed that Resident #1 was not seen by the facility psychiatric services before being sent to the hospital on [DATE].</p> <p>In an interview with the hospital social worker (staff member #11) on 04/10/25 at 1:06 PM, the hospital social worker stated that Resident #1 was still residing at the hospital since being discharge by the facility on 03/24/25 and that the facility DON informed the hospital staff that Resident #1's return was not an option. The hospital social worker stated that facility staff did not send any type of paperwork or his/her belongings with Resident #1 to the hospital on [DATE].</p> <p>(continued on next page)</p>		

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