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	06/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of facility reported incident 3018652, medical record, and interview, it was determined that facility staff failed to notify a resident's responsible party of the addition and discontinuation of treatment. This was evident for 1 (#6) of 8 residents reviewed during a complaint survey.The findings include:On 6/9/26 at 1:42 PM a review of facility reported incident 3018652 and Resident #6's medical record was conducted.A wanderguard bracelet is a discreet device worn by at-risk individuals that alerts staff when the resident approaches a monitored or restricted door. It prevents residents with memory impairment who exhibit wandering or exit seeking behaviors from exiting through the door into an unsafe environment.Review of a 2/21/26 at 1638 (4:38 PM) nurse's note documented that Resident #6 was an elopement risk per the night supervisor and a wanderguard bracelet was placed on the resident's right ankle.Further review of Resident #6's medical record failed to produce documentation that the responsible party was notified the wanderguard bracelet was applied.Review of Resident #6's May 2026 Treatment Administration Record (TAR) documented that the wanderguard bracelet was removed on 5/8/26.Review of progress notes and assessments in Resident #6's medical record failed to produce evidence that the responsible party was notified the wanderguard bracelet had been removed and discontinued.On 6/10/26 at 10:35 AM an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the responsible party should have been notified when the wanderguard bracelet was applied and when it was removed and discontinued.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of facility reported incident 3018652, medical record review, and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#6) of 8 residents reviewed for complaints during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A wanderguard bracelet is a discreet device worn by at-risk individuals that alerts staff when the resident approaches a monitored or restricted door. It prevents residents with memory impairment who exhibit wandering or exit seeking behaviors from exiting through the door into an unsafe environment.On 6/9/26 at 1:42 PM a review of facility reported incident 3018652 and Resident #6's medical record was conducted.Review of a 2/21/26 at 1638 (4:38 PM) nurse's note documented that Resident #6 was an elopement risk per the night supervisor and a wanderguard bracelet was placed on the resident's right ankle.Review of Resident #6's admission MDS with an assessment reference date (ARD) of 2/27/26, Section O, Restraints, P0200A an alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected #E. wander/elopement alarm was coded, 0 not used. The facility failed to capture the use of the wanderguard.On 6/10/26 at 12:14 PM an interview was conducted with MDS Coordinator #13. MDS #13 confirmed the findings and stated that she had seen the note and just forgot to code it on the MDS.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on investigation into a complaint, observations, record review, and staff interview, the facility failed to reassess and continue an established intervention for contracture management following a resident's readmission from the hospital. This was evident for 1 (Resident #2) of 8 residents reviewed during the complaint survey.The findings include:Hemiplegia is a severe or complete loss of strength or paralysis on one side of the body. A contracture is the abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching which can lead to permanent disability. On 6/9/26, complaint #3003711 was reviewed related to care concerns involving Resident #2.On 6/9/26 at 10:07 AM, the surveyor observed Resident #2 in bed. A right hand splint was not observed.On 6/9/26 at 3:37 PM, the surveyor again observed Resident #2 in bed. A right hand splint was not observed.On 6/10/26 at 8:05 AM, the surveyor observed Resident #2 in bed. A right hand splint was not observed.On 6/10/26 at 8:25 AM, review of Resident #2's comprehensive care plan revealed a focus stating the resident had a cerebral vascular accident (CVA/ stroke) affecting right-sided hemiplegia related to a head injury. Further review revealed interventions that included the use of a right hand splint to prevent contractures as ordered with initiated date 4/29/26.On 6/10/26 at 8:30 AM, review of Resident #2's clinical record revealed an Occupational Therapy (OT) Discharge summary dated [DATE]. The discharge summary indicated Resident #2 received OT services from 3/5/26 through 5/2/26 for contracture management, orthotic tolerance, and passive and active assisted range of motion. Further review revealed goals for Resident #2 to safely wear a resting hand splint on the right hand and documented the resident tolerated the splint for up to 3.5 hours at the time of discharge from OT services. The discharge summary indicated Resident #2 was discharged due to hospitalizationReview of Resident #2's May 2026 Treatment Administration Record (TAR) revealed a physician order dated 4/23/26 directing staff to apply a right hand splint to prevent contractures when the resident was out of bed and remove it per schedule. Further review revealed the order remained active through 5/3/26 and was not resumed following Resident #2's readmission to the facility on 5/19/26. As of 6/10/26, Resident #2 did not have an active order for a right hand splint.On 6/10/26 at 8:52 AM, an interview with the Director of Rehabilitation Services revealed Resident #2 previously received occupational therapy (OT) services which included use of a right hand splint. The Director of Rehabilitation Services stated that after discharge from OT services, Resident #2 should continue to wear the splint as part of contracture management. The Director of Rehabilitation Services further stated, We don't want the condition to get worse, and confirmed the right hand splint order had been discontinued. The Director of Rehabilitation Services stated the order was not discontinued by her.On 6/10/26 at 9:30 AM, an interview with the Physical Therapy Aide (PTA) #11 revealed Resident #2 was currently on caseload and primarily received therapy services at bedside due to his physical condition and stated, s/he doesn't wear splints that I know of.On 6/10/26 at 10:03 AM, an interview with the Director of Nursing (DON) revealed the resident would have required a new rehabilitation consult and evaluation following hospitalization before staff could resume use of the hand splint.A follow up interview with the DON revealed that Resident #2 was currently receiving physical therapy services and had been evaluated by speech therapy following readmission. The DON confirmed that OT services did not evaluate the resident following readmission, the resident did not have an active order for a right hand splint, and the resident would have required another screening or evaluation. The DON stated that because there was no order, staff would not have been applying the right hand splint. The DON further stated she would obtain an OT referral for reassessment for Resident #2.On 6/10/26 at 11:40 AM, the DON provided the surveyor with a copy of Resident #2's Therapy Referral Form dated 6/10/26. The form indicated a referral to OT for limited hand ROM/contractures and a description of problems section that indicated hand splint of right hand.The findings were reviewed with the Administrator, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Director of Clinical Operations and the Director of Nursing.At the time of exit conference, the surveyor did not observe evidence that Resident #2 had been evaluated by occupational therapy following readmission or that the established right hand splint intervention had been resumed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interviews, observations, and record review, the facility failed to ensure residents were informed of meal selections by posting current menus for resident review prior to meal service. This was evident for 1 (Resident #8) of 8 residents reviewed during the complaint survey and had the potential to affect residents who relied on posted menus to make meal selections.The findings include:On 6/10/26 at approximately 11:30 AM, an interview with Resident #8 revealed current menus were not posted for at least one week and residents were not able to review meals in advance. Resident #8 stated s/he requested a salad for lunch because s/he did not know what meal was being served. Resident #8 stated that when lunch was served, s/he learned a different meal option was available and stated s/he would have selected that meal had they known it was being served.On 6/10/26 at 11:55 AM, the surveyor observed three menus posted outside the nurses' station on the 200 unit. The menus were dated 6/1/26, 6/2/26, and 6/3/26.On 6/10/26 at 12:15 PM, an interview with the Food Service Director (FSD) revealed the facility recently transitioned to a new food service contractor and meal-tracking system and experienced difficulties printing menus. The FSD stated current menus were not posted due to issues with the printing system.The surveyor requested and reviewed the facility's menu for the current week. Review revealed the lunch meal scheduled for 6/10/26 was cranberry glazed chicken, roasted brussels sprouts, garlic red roasted potatoes, fruited gelatin, dinner roll with margarine, and beverage. During the interview, the FSD stated the lunch meal had been changed due to unavailable food items. During a follow up interview with the FSD, the surveyor asked how residents were informed of menu selections when menus were not posted. The FSD stated the menu was announced over the facility intercom prior to meal service times. The FSD further stated the menu announcement was not made today because she was on a telephone call with an outside food vendor. On 6/10/2026 at 12:47 PM, during a random tour of the facility, the FSD and surveyor observed outdated menus dated 6/1/26, 6/2/26, and 6/3/26 posted outside the nurses' station on the 200 unit. The FSD stated the outdated menus should have been removed.The findings were reviewed with the Administrator and Regional Director of Operations.At the time of exit conference, current menus were not posted for resident review prior to meal service.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of complaint 3014373, facility reported incident 3018652, medical record review, and interviews, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (#1, #6) of 8 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.1)On 6/9/26 at 11:36 AM a review of complaint 3014373 was conducted along with Resident #1's medical record.Review of a 3/6/26 at 15:26 (3:26 PM) change in condition note documented, Fall. The note documented that no changes were observed. There was no further documentation of the fall. There was no documentation of how the resident fell, what precipitated the fall, where the fall occurred, the positioning of the resident after the fall, or if there were any injuries.On 6/9/26 at 12:00 PM an interview was conducted with the Assistant Director of Nursing (ADON) who confirmed Resident #1 did have a fall.On 6/9/26 at 1:14 PM the ADON brought the surveyor a copy of the fall that was in the Risk section of the electronic medical record. The ADON was asked if risk was part of the resident's medical record and the answer was, no. Risk is a part of the electronic medical record system. The electronic medical record system also contains reports and administrative files and is not considered part of the resident's electronic medical record.On 6/10/26 at 10:35 AM the concern related to the lack of documentation after the resident's fall was discussed with the Director of Nursing (DON). The DON agreed that there should have been documentation.On 6/10/26 at 1:35 PM the concern was reviewed with the Nursing Home Administrator (NHA). The NHA stated that she had only been at the facility for 3 days after the resident fell and the resident fell on a Friday. The NHA stated she found out when she came in on Monday. She said, You can't go backwards with documentation. The NHA agreed that there should have been more documentation in the medical record.2)On 6/9/26 at 1:42 PM a review of facility reported incident 3018652 and Resident #6's medical record was conducted.Review of a 2/21/26 at 1638 (4:38 PM) nurse's note documented that Resident #6 was an elopement risk per the night supervisor and a wanderguard bracelet was placed on the resident's right ankle.A wanderguard bracelet is a discreet device worn by at-risk individuals that alerts staff when the resident approaches a monitored or restricted door. It prevents residents with memory impairment who exhibit wandering or exit seeking behaviors from exiting through the door into an unsafe environment.Continued review of Resident #6's medical record failed to produce any further documentation in progress notes, nursing notes, or physician's notes about the wanderguard.Review of physician's orders revealed the order for the wanderguard was not written until 3/5/26. There was no documentation on the February 2026 Treatment Administration Record (TAR) that the wanderguard was monitored and checked for placement all 3 shifts from 2/21/26 until 2/28/26. Review of the March 2026 TAR failed to have documentation until 3/5/26.Further review revealed the wanderguard was discontinued on 5/8/26, however there was no documentation in the medical record as to why the wanderguard was discontinued.On 6/9/26 at 2:01 PM an interview was conducted with Registered Nurse (RN) #9 who stated that the day Resident #6 was admitted to the facility the resident stated he/she wanted to leave so she put the wanderguard on. RN #6 stated that the resident was discussed during the IDT (interdisciplinary team) meetings, and it was decided that since he/she was not displaying any wandering behaviors that the wanderguard could be discontinued. On 6/10/26 at 10:35 AM the DON was informed that documentation could not be found from the nurses about the use of the wanderguard. The DON stated that it should have been on the TAR and that she knows the staff was monitoring the resident even though there was no documentation. The DON agreed with and confirmed the surveyor's findings.