

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Annapolis		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Van Buren Street Annapolis, MD 21403	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42507</p> <p>Based on review of facility reported incident investigation and interview, it was determined the facility staff failed to 1) report an alleged violation (elopement) within 2 hours to the regulatory agency, the Office of Health Care Quality and 2) report an allegation of abuse in a timely manner to the state agency, immediately, but not later than two hours after the allegation is made. This was evident for 2 residents (#83 and #98) of 2 residents reviewed for timely reporting an alleged violation during a recertification/complaint survey.</p> <p>The findings include:</p> <p>The Brief Interview for Mental Status (BIMS) score is a number between 0 and 15 that indicates a person's cognitive health: 13-15 points: The person's cognition is intact; 8-12 points: The person has moderate cognitive impairment; 0-7 points: The person has severe cognitive impairment.</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle</p> <p>1) On 12/6/2024 at 1:36 PM, review of the investigation report of Facility Reported Incident (FRI), MD00205317, revealed that on 5/2/2024 shortly after shift change, the GNA (Geriatric Nursing Assistant) noted that Resident # 98 was not in their room. Resident #98 was last seen in room at approximately 6:30 AM. Per the report, staff became aware on 5/2/2024 at 6:56 AM and the local police department was notified of a missing resident at 7:20 AM. Further review of the investigation report of the FRI revealed the resident later returned to the facility at 8:30 AM.</p> <p>However, a review of the email confirmation of the initial incident report revealed that it was submitted to OHCQ on 5/2/2024 at 5:23 PM, thus failing to meet the 2 hours reporting requirements for any alleged violations.</p> <p>On 12/9/2024 at 8:55 AM, a review of Resident #98's admission MDS (Minimum Data Set, a standardized assessment tool that measures health status in nursing home residents) with ARD (Assessment Reference Date) of 4/2/2024 revealed Resident #98 had a BIMS score of 01 (severe cognitive impairment).</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215005	If continuation sheet Page 1 of 6

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/9/2024 at 9:20 AM, a review of Resident #98's care plan revealed the resident was care planned for being at risk of elopement/wanderer r/t impaired safety awareness, Resident wanders aimlessly, initiated on 4/29/2024.</p> <p>On 12/10/2024 at 10:00 AM interview conducted with the Nursing Home Administrator (NHA): NHA confirmed that the initial report was submitted to OHCQ on 5/2/2024 at 5:23 PM. NHA stated that when the resident returned to the facility, their focus was centered on the safety of the resident and all the other residents prior to submitting the report to OHCQ.</p> <p>On 12/11/2024 at 1:21 PM in an interview with the Director of Nursing (DON) prior to survey exit, Surveyor reviewed the above FRI with her. DON was informed of surveyor's concerns regarding the facility's failure to timely report a resident elopement. No further information was provided.</p> <p>51490</p> <p>2) During review of a facility reported incident on 12/11/24 at 9:34am, it was found that an allegation of abuse was made by Resident #83 on 8/24/22 at 5:10am.</p> <p>The Self Report Form from the facility was submitted to the State Agency on 8/24/22 at 3:00pm by RN (Registered Nurse) staff #19.</p> <p>During an interview with the DON (Director of Nursing) on 12/6/24 at 1:00pm she verified the allegation of abuse should be reported within the two-hour time frame and stated the staff involved with the reporting of this citation no longer works in the facility.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42507</p> <p>Based on a facility reported incident, medical record review, and staff interview, it was determined that the facility staff failed to provide adequate supervision to a resident to prevent unsafe wandering/elopement. This was evident for 2 (#98, #29) of 2 residents reviewed for elopement during a recertification/complaint survey.</p> <p>The findings include:</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle</p> <p>A Wander guard bracelet is used to keep residents at risk of wandering/elopement comfortable and protected. It is discreet yet powerful, it triggers alarms and can lock monitored doors to prevent the resident leaving unattended.</p> <p>The Brief Interview for Mental Status (BIMS) score is a number between 0 and 15 that indicates a person's cognitive health: 13-15 points: The person's cognition is intact; 8-12 points: The person has moderate cognitive impairment; 0-7 points: The person has severe cognitive impairment.</p> <p>1) On 12/6/2024 at 1:36 PM, review of the investigation report of Facility Reported Incident (FRI), MD00205317, revealed that on 5/2/2024 shortly after shift change, the GNA (Geriatric Nursing Assistant) noted that Resident # 98 was not in their room. Resident #98 was last seen in their room at approximately 6:30 AM. Per the report, staff became aware on 5/2/2024 at 6:56 AM and the local police department was notified of a missing resident at 7:20 AM. Further review of the investigation report of the FRI revealed Resident #98 later returned to the facility at 8:30 AM in very good spirits and indicated that s/he was hungry and went for a walk. The report further indicated that staff did not observe the resident leave their room/facility and described the resident as alert and oriented x1 (AO x1 means that a person knows who they are but not where they are, what time it is, or what is happening to them). Further review of the report revealed that all door alarms were functional and resident had a functioning device (wander guard) on their wrist, and suspicion was that Resident #98 climbed out of a room window.</p> <p>On 12/9/2024 at 8:55 AM, a review of Resident #98's admission MDS (Minimum Data Set, a standardized assessment tool that measures health status in nursing home residents) with ARD (Assessment Reference Date) of 4/2/2024 revealed Resident #98 had a BIMS score of 01 (severe cognitive impairment).</p> <p>On 12/9/2024 at 9:20 AM, a review of Resident #98's care plan revealed the resident was care planned for being at risk of elopement/wanderer r/t impaired safety awareness, Resident wanders aimlessly, initiated on 4/29/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/2024 at 10:00 AM, in an interview with the Nursing Home Administrator (NHA), he confirmed that the resident left the building/facility without staff observation/knowledge and was gone for almost one and a half hours unaccounted for. NHA stated that one of the windows in the resident's room was partly opened and they suspected Resident #98 climbed out through that window. However, NHA stated that all the windows in the facility have now been secured with brackets that would not allow them to be opened past a certain level. He further stated that the exit doors were checked and all alarm doors were functional. He added that the resident's wander guard bracelet and those of the other residents in the building at the time were checked and they were all working properly.</p> <p>On 12/11/2024 at 1:21 PM in an interview with the Director of Nursing (DON), Surveyor reviewed the above FRI with her. Surveyor shared concerns regarding the facility's failure to supervise/prevent a resident with risk of wandering /elopement from leaving the building/facility. No new information was provided.</p> <p>2) On 12/9/2024 at 11:15 AM, review of Facility Reported Incident MD00191220 revealed that on 4/11/2023 rehab staff observed Resident #29 sitting in a wheelchair on the sidewalk in close proximity to the front of the facility. When asked by the rehab staff how s/he got out, the resident pointed to the side door. Resident was escorted back inside and was not in any acute distress. The report indicated that upon reports that Resident #29 was observed outside of the facility, the Nursing Home Administrator (NHA) immediately checked the side door off Station 1 unit and found the door slightly ajar.</p> <p>On 12/9/2024 at 12:33 PM, review of Resident #29's medical records revealed a quarterly MDS with ARD of 5/4/2023 revealed the resident had a Brief interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment.</p> <p>On 12/10/2024 at 9:37 AM, an interview was completed with the Nursing Home Administrator (NHA), he stated that the resident was wearing his/her wander guard which was intact and functioning. He stated that Resident #29 was the only resident with a wander guard at the time that was very mobile. However, he added that the alarm did not go off when the resident went out the door. When asked how the resident was able to exit the building with a wander guard in place, NHA stated the door malfunctioned. However, he added that facility staff manned the door until it was fixed by an outside vendor/technician. All doors were checked by the technician and were functioning correctly. NHA added that an elopement action plan was initiated, and continued safety checks were conducted and ongoing.</p> <p>On 12/11/2024 at 1:21 PM in an interview with the Director of Nursing (DON), Surveyor reviewed the above FRI with her. DON was informed of surveyor's concerns regarding the facility's failure to ensure that a cognitively impaired resident with exit seeking behaviors did not leave the building unauthorized. DON provided no new information regarding the deficient practice.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>44441</p> <p>Based on record review and staff interviews, it was determined that the facility failed to follow up with pharmacy recommendations after the monthly reviews were completed. This was evident for 2 (#56 and #10) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey.</p> <p>The Findings include:</p> <p>Abnormal Involuntary Movement Scale (AIMS) evaluation is a 12-item rating evaluation scale use to assess the severity of abnormal movements which is a side effect of certain antipsychotic medications.</p> <p>On 12/5/24 at 9:36 AM: Review of Resident #56's monthly pharmacy review from September to December 2024 revealed that the pharmacist found some irregularities in September, November and December. Further review showed that September and November recommendation forms could not be found. The Director of Nursing (DON) was asked to provide the reports.</p> <p>On 12/5/24 at 9:46 AM Review of the Pharmacy Drug regimen review from January to December 2024 for resident #10 revealed irregularities for the months of August, October and December, the facility provided the December review form but did not provide the August and October review form, they were asked to provide it.</p> <p>On 12/5/24 at 10:26 AM, The DON provided the recommendation forms for Resident #56 and on review it showed that in the month of September (9/3/24) the pharmacist recommended: Abnormal Involuntary Movement Scale (AIMS) evaluation now and every 6 months Resident #56 was on Quetiapine (Seroquel) an antipsychotic medication use to treat Schizophrenia, bipolar disorder and depression. The Physician was not made aware of this recommendation, so it was never implemented. On 11/4/24, after the pharmacist completed the monthly medication regimen review (MRR), the pharmacist again recommended that the AIMS evaluation be done.</p> <p>On 12/5/24 at 10:26 AM, The DON also provided the October 2024 Pharmacy Recommendation forms for resident #10. Review of the forms revealed that the pharmacist recommended a fasting lipid panel for Resident #10 who was on Atorvastatin, a cholesterol lowering medication. This recommendation was never carried out until 12/2/24 when the pharmacist did another monthly review and recommended it again.</p> <p>Review of the Facilities MRR policy on 12/6/24 at 10:00 AM with revision date of 2/15/24 documented that the Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities within 30 days.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/06/24 at 9:15 AM in an Interview with the DON she was asked the process for carrying out pharmacy recommendations. She stated that the pharmacist once done with the reviews, would put their notes in (PCC) electronic record and then email a link to her and her assistant (ADON) to access. The Assistant Director of nursing (ADON) then prints out the recommendations and disperses them to the unit managers, The unit managers would talk with the physicians about the recommendations and get their feed back and signatures. The physicians would either agrees or disagrees with the recommendations to implement. This is then uploaded in the electronic records She stated that the ADON provides oversight to make sure all this was done.</p> <p>The ADON was asked in an interview on 12/06/24 at 9:20 AM the process for providing oversight. She stated that the unit Managers are responsible for making sure that Physicians see and address all recommendations before sending it to her. She double checks to make sure that recommendations were addressed before uploading. She was asked the time expectation for the physicians to see the recommendations and she said it's within 7 days but would need to verify the policy. She was made aware of the recommendations that were delayed and not carried out, she said she was aware of it and they're working on it</p>		