STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215005	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Annapolis	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)
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. 42507 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. The findings include: 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. 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 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. 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. 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). (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 51490 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. 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. 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.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42507 Based on medical record review and staff interview it was determined the facility staff failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (#65) of 2 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: During an initial screen of Resident #65 on 12/5/2024 at 7:51 AM, the resident stated that s/he was recently hospitalized . On 12/5/2024 at 8:48 AM a review of nurses' progress notes and change in condition documentation dated 12/1/2024 at 7:16 AM revealed Resident #65 was sent to the ER (emergency room) via 911 on 12/1/2024 for altered mental status. However, there was no documentation/evidence that the resident and/or daughter was notified in writing the reason for transfer to the hospital. On 12/5/2024 at 9:15 AM an interview was conducted with Licensed Practical Nurse (LPN #14). Regarding written notification of reason for transfer to the hospital, LPN #14 stated that the reason for transfer was documented in the change in condition form included in the transfer packet sent with the resident to the hospital. She stated that the residents were notified verbally of the reason for transfer to the hospital. LPN #14 added that family members/RP (Resident Representative) were notified of reason for transfer verbally in person if they were present in the building, and over the phone if they were not present. She confirmed that she has not given in writing the reason for transfer to the hospital to any resident and/or their RP. On 12/5/2024 at 9:27 AM, in an interview with Licensed Practical Nurse (LPN #13) who has worked in the facility for over 6 years, she confirmed that she has never given any resident and/or their RP the reason for transfer to the hospital in writing. On 12/5/2024 at 9:35 AM, a follow up interview was conducted with Resident #65. The resident stated that s/he was told verbally the reason for the transfer to the hospital but s/he was not given anything in writing regarding the reason for transfer. On 12/5/2024 at 11:09 AM, an interview was held with the Director of Nursing (DON). DON stated that the reason for transfer was documented in the transfer form sent with the resident to the hospital. She added that a copy of the transfer form was later mailed to the RP by the Nursing Home Administrator. When asked to provide a copy of the transfer notice that was mailed to Resident #65's RP, DON stated that she could not find any documentation to show that the resident and/or their RP were given in writing the reason for transfer to the hospital on 12/1/2024. She further confirmed that they did not mail the transfer form that had the reason for transfer to the hospital to the RP because Resident #65 returned to the facility within 24 hours.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42507 Based on medical record review and staff interview it was determined the facility staff failed to notify the resident/resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. This was evident for 1 (#65) of 2 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . During an initial screen of Resident #65 on 12/5/2024 at 7:51 AM, the resident stated that s/he was recently hospitalized . On 12/5/2024 at 8:48 AM a review of nurses' progress notes revealed a change in condition documentation dated 12/1/2024 at 7:16 AM that noted Resident #65 was sent to the ER (emergency room) via 911 on 12/1/2024 for altered mental status. Further review of the change in condition form revealed Resident #65's daughter was present at time of transfer to the hospital. However, there was no documentation and/or evidence in the record indicating that the facility staff notified the resident/resident's representative (RP) in writing of the facility's bed hold policy. On 12/5/2024 at 9:15 AM an interview was conducted with Licensed Practical Nurse (LPN #14). Regarding bed hold, LPN #14 stated that the facility's bed hold policy was included in the transfer packet given to the 911 transporters when a resident was being sent to the hospital. She stated that residents were informed verbally about the bed hold policy. LPN #14 confirmed that s/he has never given any written bed hold policy notification to a resident and/or their representative (RP) upon transfer to the hospital. On 12/5/2024 at 9:27 AM, an interview was held with Licensed Practical Nurse (LPN #13) who has worked in the facility for over 6 years. Regarding bed hold notification, LPN #13 stated that she has never given residents and/or their RPs a copy of the bed hold notification upon transfer to the hospital. She stated that the bed hold policy was included in the transfer packet sent to the hospital upon transfer but not given to the resident and/or their RP. However, LPN #13 added that the resident and RP were notified verbally of the bed hold policy. On 12/5/2024 at 9:35 AM, in a follow up interview with Resident #65, the resident stated that s/he was not given any written notification of the facility's bed hold policy. However, Resident #65 affirmed that s/he was readmitted to their same room upon return to the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at 11:09 AM, an interview was held with the Director of Nursing (DON). DON stated that the facility's bed hold policy was usually sent with the transfer packet to the hospital and a copy mailed to the RP by the Nursing Home Administrator (NHA). When asked to provide a copy of the bed hold notification that was mailed to Resident #65's RP when the resident was transferred to the hospital on 12/1/2024, DON stated that she could not find any documentation to show that the resident and/or their RP were given any written notification of the bed hold policy. Surveyor reviewed the change in condition and transfer form with checklist sent with Resident #65 on 12/1/2024: DON confirmed that both did not indicate that the bed hold policy was included in the packet. On 12/5/2024 at 12:50 PM, in a follow up interview with the DON, surveyor shared concerns regarding written notifications of bed hold upon transfer/discharge of a resident to the hospital. DON stated that she has done her audits and Resident #65 was the only resident they missed giving the transfer notice and bed hold policy to.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 50904 Based on medical record review, staff interview, and observation, it was determined that the facility staff failed to provide an activities program to meet the needs and preferences of residents by 1) not performing activities with residents per care plan and 2) not documenting care plan activities. This was evident for 1 resident (Resident #31) reviewed during the Medicare/Medicaid recertification survey. The findings include: On 12/04/24 at 11:29 AM, during a phone interview with Resident #31's mother, she told the surveyor that Resident #31 had activities as part of his/her care plan, but the activity staff had not seen him/her. On 12/06/24 at 9:01 AM, the surveyor reviewed the electronic record for the resident and the care plan showed that Resident #31 had little, or no activity involvement related to physical limitations initiated on 05/06/2022, the goal was that Resident #31 will participate in activities of choice while in the room due to physical limitations and was revised on: 08/06/2024 with a target date of 11/30/2024. It also showed the intervention which was that the activity staff will have one-on-one in-room activities/ music therapy once a day and 3 times every week. The surveyor reviewed the activity log in the electronic record but could not find any activity documentation. On the same day at 09:06 AM, in an interview with the unit manager Staff #8, when asked about how activities were done and the type of activities done with Resident #31, she stated that the activity staff just goes into the room to look at the resident and does not know the type of activities done with the resident. On the same day at 09:14 AM, in an interview with the Activities Director Staff#10, she was asked about the activities done with the Resident#31, she stated that she provides music therapy as well as reading the daily news to him/her. She stated that the activity was one-on-one. She also stated that it should have been done 3 times per week according to Resident #31's care plan but it was not consistent. When she was asked how activities were documented, she told the surveyor that the activity done with all residents was noted in a participation log sheet while the activity was ongoing, then it would be transferred into the activity log in Point Click Care (PCC) an electronic record and the log sheet would be shredded afterwards. When she was asked for a 3-month activity log sheet for the resident, she stated that there had been no documentation of the one-on-one activities done with the resident and added that going forward, she would ensure that she and other activity staff members perform the activities with the resident and document it appropriately. 12/06/2024 at 9:28 AM, the surveyor informed the Director of Nursing about the concerns with Resident #31's activities and documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51490 Based on observations, medication record review and interview with facility staff, it was determined that the facility failed to direct a resident (#45) to rinse their mouth after the administration of an inhaler as ordered by the physician. This occurred for one (Resident #45) of four residents observed during a medication observation during the recertification/complaint survey. The findings include: During medication observation on 12/10/24 at 9:22am, LPN (Licensed Practical Nurse) staff #16 administered Trelegy inhalation to Resident #45. Trelegy is a prescription medicine used long term to treat COPD (chronic obstructive pulmonary disease). Review of the medical record on 12/10/24 at 10:39am revealed a physician order dated 12/5/24 to administer Trelegy one inhalation Inhale orally (by mouth) one time a day for COPD. Rinse mouth after use. Staff #16 failed to instruct resident #45 to rinse his/her mouth after the inhalation of the Trelegy. During interview with the Director of Nursing on 12/10/24 at 12noon she verified the findings. She stated the nurse realized her error and she was in-service on reading the entire order prior to administration of medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50904 Based on observations, review of records and interview with facility staff and resident, it was determined that the facility failed to provide necessary respiratory care services for residents by failing to implement the physician order for a resident with tracheostomy. This was evident for 1 resident (Resident #54) reviewed for respiratory care during the Medicare/Medicaid recertification survey. The findings include: On 12/04/24 at 08:46 AM, during the initial tour of the facility, Resident #54 complained to the surveyor that his/her Passy-Muir valveSpeaking Valve (A Passy-Muir valve is a medical device that helps tracheostomy and ventilator patients communicate and maintain their airway) had not been changed since he/she got to the facility about one year ago. He/She added that he/she had a prescription from the Ear Nose and Throat (ENT) physician for a speaking valve since April 2024 and another prescription for the same valve and a tracheostomy collar in November 2024, but the facility had not replaced it. He/She provided a copy of the prescription to the surveyor. On 12/06/24 at 08:21 AM, in an interview with unit 1 manager Staff #8, she was asked about how Resident #54 gets his/her supplies for the tracheostomy. She told the surveyor that the resident visits the Ear Nose and Throat (ENT) physician monthly and after he/she returns from the appointment, she or the unit secretary/nurses checks for new recommendations/orders/prescriptions to be implemented. When she was asked how often the resident's speaking valve was replaced, she stated that the ENT physicians always give an order for replacement. She stated that she was not sure when the last valves were changed and that the facility had just ordered new valves because the resident's physician had recommended it recently. When she was informed about Resident #54's prescription for a clear speaking valve replacement since April 2024 and asked why it has not been implemented, she stated that she was aware of the prescription and had thought that the resident would get the supply through the respiratory therapist, but it turned out that the respiratory therapist does not give out supplies anymore. She added that the resident was given another prescription for the clear speaking valve and trach collar replacement in November 2024 and that the facility is waiting for the supplies to be delivered through the Administrator. On 12/06/24 at 08:48 AM, the surveyor notified the Director of Nursing about the concern identified and she stated that she was not aware that there was an issue with the supply. On the same day at 08:52 am, the Administrator was informed about the concern, and he stated that he became aware of both prescriptions on 12/06/2024 through the Resident #54's responsible party and that he placed an order for both immediately. He also stated that the supplies would be in the facility by the weekend.