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Form Approved OMB
No. 0938-0391

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 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Annapolis	900 Van Buren Street Annapolis, MD 21403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review, interview with residents, and the facility staff, it was determined that the facility failed to ensure that quarterly resident fund account statements were provided to residents. This was evident for four residents (Residents #86, # 1, #3 and #47) out of five residents reviewed for personal funds during the facility's recertification survey.The findings include:On 03/06/2026 at 7:45 AM, during the initial tour of the facility, some residents provided statements regarding quarterly statement of account as follows.On 03/03/2026 at 9:09 AM, Resident #86 stated that he/she did not receive a quarterly statement.On 03/03/2026 at 9:42 AM, Resident#1 stated that he/she had an account with the facility but had never received statements and requested that statements be provided.On 03/03/2026 at 10:05 AM, Resident #3 stated that he/she had never received a statement of account.On 03/03/2026 at 11:55 AM, Resident #47 stated that he/she did not always receive quarterly fund statements.On 03/06/2026 at 10:11 AM, the surveyor requested that the Business Office Manager (BOM) provide a list of residents with accounts at the facility.On 03/06/2026 at 10:26 AM, the list was provided and reviewed.On 03/06/2026 at 10:33 AM, in an interview with the BOM, when asked how statements were given to residents, she stated that statements were given monthly to residents who requested them and quarterly to all other residents. When asked if records of distributed statements were maintained, she stated that a binder was maintained for this purpose, which the surveyor requested for review.On 03/06/2026 at 11:12 AM, in a follow-up interview with the BOM, when asked for the facility's protocol for providing statements, she stated that residents or their responsible parties were to sign a copy of the receipt as acknowledgment of receiving the statement.On 03/06/2026 at 11:15 AM, the surveyor reviewed the statements for residents who reported not receiving them. The review failed to show acknowledgments that residents had received the statements. The BOM confirmed that there was no evidence that the residents had received the quarterly statements.On 03/06/2026 at 11:24 AM, in an interview with the Nursing Home Administrator (NHA), when asked about the process for providing quarterly statements to residents or responsible parties, he stated that statements were provided in person to capable residents and mailed or emailed to residents with responsible parties quarterly or per request and acknowledged copies were kept.On 03/06/2026 at 11:26 AM, when informed of the concerns regarding the failure to provide quarterly statements to residents, the NHA acknowledged the concern.

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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NAME OF PROVIDER OR SUPPLIER Complete Care at Annapolis		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Van Buren Street Annapolis, MD 21403	

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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. Based on interviews, observations and record reviews, it was determined that the facility failed to revise residents care plan in a timely manner and implement the care plan interventions. This was evident for 2 (Resident #93 and #8) out of 2 residents reviewed for falls during the annual survey. The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.1). On 3/03/2026 at 8:39 AM, an interview with Resident #93 was conducted. They reported that they fell a while ago. During the interview, the surveyor observed the bed to be in a high position. On 3/04/2026 at 1:10 PM, the surveyor observed Resident #93's bed in a high position when interviewing the resident regarding their oral care.On 3/05/2026 at 11:39 AM, a review of Resident #93's medical records was conducted. The review revealed that the resident had an actual fall on 1/13/2025. Further review of the care plan revealed a statement that indicated Resident #93 was at high risk for falls related to deconditioning and history of multiple falls. The interventions included neuro-checks to be completed. On 3/06/2026 at 7:55 AM, an interview with the unit manager was conducted. She reported that the resident is at risk for falls. When asked what interventions were implemented to prevent future falls, staff replied that the call bell should be near the resident and staff rounds. At this time, the surveyor pointed out that Resident #93's bed was in a high position. On 3/06/2026 at 8:20 AM, a review of the facility's fall prevention policy was conducted. The review indicated that residents who were identified as low/moderate fall risk should have the bed locked and lowered to a level that allowed resident's feet to be flat on the floor when sitting on the edge of the bed. For residents identified as high fall risk, additional interventions included increased frequency of rounds, low bed, floor mat and assess the room configuration.On 3/06/2026 at 8:55 AM, the facility was asked to provide evidence that neuro-checks were completed after Resident #93 fell as indicated on the care plan interventions. On 3/06/2026 at 10:21 AM, an interview with the Director of Nursing (DON) conducted. She reported that there was no evidence that the neuro-checks were done. When asked what the expectations were on updating the care plan, she stated that the care plans should be revised immediately or as soon as possible after a fall occurs. The DON also clarified that the care plan revisions should have included to keep Resident #93's bed in the lowest position and wheels locked. 2). On 3/03/2026 at 9:24 AM, an interview with Resident # 8 was conducted. The resident reported that they fell off the bed in January 2026, fractured their hip and were sent to the hospital.On 3/04/2026 at 8:50 AM, a review of Resident #8's medical records was conducted. The review revealed that the resident had an unwitnessed fall on 1/6/2026. Records also indicated that the resident was on a blood thinner medication called Plavix. Review of the care plan indicated revisions that were made 3 days after the fall, on 1/9/2026. The interventions stated, continue with at risk plans and to perform neuro-checks per facility policy.On 3/04/2026 at 9:20 AM, the facility was asked to provide evidence that the neuro-checks were completed after the resident's fall incident.On 3/06/2026 at 10:54 AM, an interview with the DON was conducted. When asked what actions should be taken after a resident falls, the DON reported that a post fall assessment should be completed, care plan should be updated, vitals signs and neurological assessment should be completed per facility's protocol. She further stated that it was the facility's protocol to perform neuro-checks for any resident who has had an unwitnessed fall. The DON added that there was no evidence to indicate that neuro checks were completed after Resident #8 fell. Additionally, she also acknowledged that the care plan revisions were not revised in a timely manner.On 3/06/2026 at 11:04 AM, at this time the surveyor discussed with the DON concerns with care plan revisions and failure to implement the post fall interventions as indicated on the care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interviews and observations it was determined that the facility failed to utilize Video Remote Interpreting (VRI) services to communicate with deaf residents. This was evident for 1 (Resident #47) out of 4 residents reviewed for communication-sensory impairment during the annual survey. Video Remote Interpreting (VRI) is a service that uses video technology to connect a deaf or hard of hearing person with a sign language interpreter who appears on a screen (tablet, computer, or monitor). The interpreter signs what the staff say and voices what the resident signs so both sides can understand each other. The findings include: On 03/03/2026 at 8:25 AM, the surveyor observed a sign outside Resident #47's room indicating that the resident was deaf. At the same time, an interview with Geriatric Nurse Assistant (Staff #7), revealed that she communicated with Resident #47 through written communication. On 03/03/2026 at 9:13 AM, an interview with Geriatric Nurse Assistant (Staff #8), revealed that she communicated with Resident #47 through written communication. On 03/03/2026 at 12:10 PM, an interview with Resident #47 revealed that written communication was not the resident's preferred method of communication. At the same time, an observation of the Resident #47's room revealed that there was a VRI tablet in the room. On 03/05/2026 at 8:05 AM, an interview with Licensed Practical Nurse (Staff #14) revealed that her form of communication with Resident #47 was through facial expressions and writing. It was also revealed that staff rarely used the VRI tablet in the resident's room. On 03/05/2026 at 8:08 AM, an interview with Resident #47 revealed that staff rarely use the VRI tablet as a form of communication. On 03/05/2026 at 9:53 AM, an interview with the Director of Nursing revealed that the expectation was that staff use the VRI system in place for Resident #47 throughout the day during care. On 03/05/2026 at 11:34 AM, surveyor requested Geriatric Nurse Assistant (Staff #8) to obtain an interpreter on the VRI system; however, Staff #8 was unable to do so because she did not know how to use the system. On 03/05/2026 at 11:37 AM, the surveyor requested Licensed Practical Nurse (Staff #14) to obtain an interpreter through the VRI system, and Staff #14 was unable to do so. On 03/05/2026 at 1:09 PM, the concern was reviewed with the Assistant Director of Nursing and she indicated that she understood.

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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. Based on interviews and medical record review, it was determined that the facility staff failed to provide oral hygiene care and showers to dependent residents. This was evident for 2 (Resident #93 and #86) out of 3 residents reviewed for Activities of Daily Living (ADL) care during the annual survey.The findings include:1). On 3/03/2026 at 8:39 AM, an interview with Resident #93 was conducted. They reported that no one at the facility cleaned their teeth and that a family member came in to the facility to assist with oral hygiene once a week. On 3/04/2026 at 12:02 PM, a review of Resident #93's medical records was conducted. The review revealed Minimum Data Set (MDS) Section GG that indicated the resident required partial/moderate assistance to perform oral hygiene. Further review of the resident's care plan indicated that the resident had an ADL self-care deficit related to fatigue and tremors to upper extremities. It also stated that the resident required extensive assistance to maximize independence.On 3/04/2026 at 1:10 PM, a follow up interview with Resident #93 was conducted. When asked if they had received oral care in the morning, the resident stated no. On 3/04/2026 at 1:19 PM, a review of Resident #93's electronic record was conducted. The review revealed a task titled oral hygiene that had several shifts documented as not applicable.On 3/04/2026 at 1:27 PM, an interview with Staff #17 was conducted. When asked if she had provided oral care to Resident #93, the staff replied no. She further explained that she had to provide residents with their lunch trays first and therefore she had not had a chance to provide oral care to the resident. On 3/04/2026 at 1:43 PM, the facility was asked to provide documentation that Resident #93 was provided with oral hygiene. On 3/04/2026 at 1:51 PM, an interview with the Director of Nursing (DON) was conducted. When asked what not applicable under oral hygiene meant, she stated she was not aware. She further stated that Geriatric Nursing Assistants (GNAs) also document provision of oral care under oral care task. The surveyor asked for documentation on oral care provided to the resident in the last 30 days as well as the facility's oral care policy. On 3/05/2026 at 7:12 AM, a follow up interview with the DON was conducted. She stated that the facility's oral policy does not specify the frequency in which oral hygiene or oral care should be provided to residents. However, it was the facility's protocol to provide residents with oral hygiene twice a day, in the morning and at night. On 3/05/2026 at 7:40 AM, the surveyor was provided with Resident #93's oral care documentation for the last 30 days. The review was conducted with the DON present. 7 (2/14, 2/15, 2/18, 2/27, 2/28, 3/1 and 3/4) out of the 30 days, Resident #93 was not provided oral care per facility's protocol. On 3/05/2026 at 7:44 AM, the DON was made aware of the oral care concerns. 2). On 3/03/2026 at 9:17 AM, an interview with Resident #86 was conducted. They reported that they had not had a shower for the last 5 weeks. They also added that they would like to get showers more often if given an opportunity. On 3/04/2026 at 8:01 AM, a review of Resident #86's medical record was conducted. The review revealed a care plan that indicated the resident had a self-care performance deficit related to limited mobility. The care plan also indicate that Resident #86 was totally dependent on staff to provide showers on preferred days.A review of the unit's shower schedule indicated that Resident #86 was supposed to get showers on Mondays and Thursdays. Further review of Resident #86's MDS Section GG, revealed that the resident was coded for partial/Moderate assist for showers. Under section F, for resident preferences, it was coded that it was very important for Resident # 86 to choose between shower and bed bath. On 3/05/2026 at 8:00 AM, the facility was asked to provide evidence that Resident #86 was offered or given a shower for the last 30 days.On 3/05/2026 at 8:50 AM, the facility provided shower document records from 2/5/2026 to 3/5/2026. The review of these records indicated that Resident #86 had showered once (2/9/2026) for the last 30 days. On 3/05/2026 at 9:08 AM, an interview with Staff #14 was conducted. She reported that it was the responsibility of Geriatric Nurse Assistants (GNAs) to offer and provide showers to residents. She also confirmed that in the last 30 days, she had never given Resident #86 a shower or assisted a GNA with providing the resident with a shower.On 3/05/2026 at 9:28 AM, the Facility Administrator was notified of the showers concern.

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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. Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that oxygen administration equipment was dated and labeled after being changed in accordance with physician orders and facility expectations. This was evident for 2 (Residents #109 and #20) out of 2 residents reviewed for oxygen therapy during the facility's recertification/complaint survey. The findings include: On 03/03/2026 at 7:59 AM, during the initial tour of the facility, Resident #109 was observed eating breakfast in bed. The resident was receiving oxygen at 2 LPM via nasal cannula. The nasal cannula tubing was observed without a date or label.On 03/03/2026 at 8:11 AM, during the continued tour, Resident #20 was observed in bed preparing to eat breakfast. The resident was receiving oxygen at approximately 1.8 LPM via nasal cannula. The nasal cannula tubing was observed without a date or label.On 03/04/2026 at 7:27 AM, a review of the physician's orders for Resident #20 indicated an order for oxygen at 2 L/min via nasal cannula as needed for shortness of breath (SOB). The order also indicated that the oxygen humidifier bottle and tubing were to be changed weekly and as needed if visibly soiled, and that each component be labeled with the date and staff initials, scheduled every Sunday on the night shift.On 03/04/2026 at 7:33 AM, a review of the physician's orders for Resident #109 indicated an order for oxygen at 2 L/min via nasal cannula continuously for COPD. The order also indicated that the oxygen humidifier bottle and tubing were to be changed weekly and that each component be labeled with the date and staff initials, scheduled every Sunday on the night shift.On 03/04/2026 at 9:47 AM, during a follow-up observation, Resident #109 was observed in bed receiving continuous oxygen at 2 LPM via nasal cannula. The nasal cannula tubing remained without a date or label.On 03/04/2026 at 10:13 AM, during an interview with the Unit 1 Manager, Licensed Practical Nurse (LPN #10), when asked if she had received training on administration of oxygen and care for oxygen equipment, she confirmed that she had received training on oxygen administration. When asked about the expectations regarding oxygen tubing and humidifiers, she stated that they should be changed weekly and as needed. When asked what should occur after changing the tubing, she stated that the equipment should be dated and labeled.On 03/04/2026 at 10:18 AM, during a follow-up observation of Resident #20, the nasal cannula tubing was observed without a date or label.On 03/04/2026 at 10:19 AM, LPN #10 was asked to perform a dual observation with the resident and was asked when the nasal cannula tubing was last changed. She stated that she could not determine when it was last changed because there was no date on the nasal tubing. She stated that the nasal tubing would be changed and dated.On 03/04/2026 at 10:21 AM, during an interview with Registered Nurse (RN #11) who was present during the observation, the RN stated that the expectation for care of oxygen equipment, specifically nasal cannula tubing, was that it should be changed weekly and dated.On 03/04/2026 at 12:39 PM, during an interview with the Director of Nursing (DON), she stated that the expectation for oxygen equipment was that tubing should be changed weekly on Sundays and dated after each change.On 03/04/2026 at 12:41 PM, when informed of the concern regarding oxygen tubing not being dated or labeled, the DON acknowledged the concern.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on resident interview, record review, and staff interview, it was determined that the facility failed to administer time sensitive medication on time. This was evident for 1 (Resident #108) out of 7 residents reviewed during the recertification survey. The findings include: On 3/03/2026 at 9:53 AM, an interview with Resident #108 was conducted. The resident complained that the facility staff administered their seizure medications late.On 3/10/2026 at 9:30 AM, a review of the Medication Administration Audit was conducted. The audit revealed that Levetiracetam oral tablet 1000 mg, an anticonvulsant, was ordered to be given by mouth on 3/1/2026 at 9 PM and was given on 3/2/2026 at 9:24 AM by Staff #26. Lamotrigine oral tablet 150 mg, an anticonvulsant, was ordered to be given on 3/6/2026 at 5 PM and was given on 3/6/2026 at 8:25 PM by Staff #27. Levetiracetam oral tablet 1000 mg was ordered to be given by mouth on 3/7/2026 at 9 PM and was given on 3/7/2026 at 10:15 PM by Staff #18.Lamotrigine is a time-sensitive medication that requires strict adherence to a specific dosing and titration schedule to maintain safety and efficacy.The timely administration of Levetiracetam, or Keppra, is medically critical because of its relatively short half-life and the high risk of breakthrough seizures associated with inconsistent blood levels.On 3/10/2026 at 9:42 AM, an interview with the Director of Nursing (DON) was conducted. The surveyor made the DON aware of Resident #108's concern with the timing of medication administration. The surveyor reviewed the findings from the Medication Administration Audit with the DON and confirmed the findings. The DON stated that they received a request from the resident recently to adjust the medication times because the staff was not administering the medications on time. The DON stated that the medication was given late and the nursing staff is expected to give medications in a window of 1 hour before to 1 hour after the due time.

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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. Based on observations, interviews and record reviews, it was determined that the facility failed to provide residents' food in accordance with the resident's preferences. This was evident for 2 (Resident #8 and #39) out 4 residents reviewed for dining during the annual survey. The findings include:1). On 3/06/2026 at 12:48 PM, Resident #8's lunch meal was observed. The surveyor noted that the portions of meals were regular. The lunch meal ticket was reviewed and indicated that the resident was to be served large portions. On 3/06/2026 at 12:50 PM, a brief interview with Resident #8 was conducted. They reported that the meal ticket do not match what is served. When asked how often it occurred, the resident replied, so many times.On 3/06/2026 at 1:22 PM, an interview with the Staff #25, the facility's Food Director, was conducted. The surveyor showed Staff #25 the meal portions served to Resident #8. When asked if the portions were considered large as indicated on the meal ticket, the staff confirmed that the food portions served were regular and not large. 2). On 3/06/2026 at 12:52 PM, another dining observation was conducted. Resident #39's meal ticket was reviewed, it stated to serve green beans and do not serve peas. The meal served to Resident #39 included peas and carrots, no green beans were observed. On 3/06/2026 at 12:55 PM, a brief interview with Resident #39 was conducted. When asked if they had eaten the peas and carrots, the resident said no. On 3/06/2026 at 12:57 PM, another interview with Staff #14 was conducted. Staff confirmed that Resident #39 was not served green beans for lunch. She also confirmed that the meal ticket indicated that the resident should not be served peas. On 3/09/2026 at 10:56 AM, another interview with Staff #25 was conducted. When asked who was responsible for updating the resident's meal preferences, she stated that it was the dietician responsibility. She also stated that if a resident had a pattern of refusing certain meals or portions, it was the facility's expectation to honor the meal preferences and update the meal tickets as soon as possible. On 3/09/2026 at 1:32 PM, the Director of Nursing (DON) was notified of the meal preferences concerns.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, it was determined that the facility failed to store food products in accordance with professional standards for food safety. This was evident in 3 out of 3 food storage areas observed during the initial Kitchen tour.The findings include:On 3/03/2026 at 7:43 AM, an initial tour of the kitchen with the Food Service Director was conducted. A Turkey Gravy Mix was observed without an expiration date, though the received date of 2/23/2026 was printed on it. Other non-perishable items without expiration dates included a bottle of maple syrup. Perishable items found without expiration dates included 1 bag of frozen corn dogs, 1 bag of frozen meatballs, and a container of garlic. 4 bags of bread rolls, each containing about 12 rolls, were observed with an expiration date of 2/26/2026. A bottle of Teriyaki sauce had an expiration date of November 2025. A container of peeled boiled eggs had an expiration date of 2/26/2026. The Food Service Director threw out all expired items.On 3/03/2026 at 7:45 Am, during the brief tour of the fridge, the surveyor observed 6 containers with cooked foods. These containers did not have a label to identify the cooked items as well as no date to discard the foods. A follow up interview was conducted with the Food Service Director. When asked if the cooked foods should be labeled, she stated yes, that it was the facility's protocol to write what the name of the cooked item as well as the expiration or use by date. On 3/04/2026 at 8:05 Am, the surveyor notified the facility administrator of the food labeling and storage concerns identified during the kitchen tour.