STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215096	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Multi Medical Center LLC	7700 York Road Towson, MD 21204

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on medication administration observation, medical record review and staff interview, it was determined that the facility staff failed to ensure a medication error rate of less than 5%. This was evident for 11 out of 41 medications administered during the medication administration facility task which resulted in an error rate of 26.83%.The findings include:1) During a medication administration observation that took place on 2/25/26 at 7:59 AM, the surveyor observed Licensed Practical Nurses (LPN #6) administer medications to Resident #43. The medications included 1 tablet of Zyrtec 10mg (milligrams). Review of Resident #43's medical record on 2/25/26 at 9:50 AM revealed the following order: Zyrtec Allergy Oral Tablet 10mg. Give 1 tablet by mouth one time a day for increased respiratory congestion and cough x 7 days with an order date of 1/16/26. On 2/25/26 at 10:53 AM in an interview with LPN #6 when asked to read the Zyrtec order for Resident #43, she opened the laptop on the medication cart, pulled up the order, and read it aloud. When asked how long the resident was supposed to receive the medication, she said, He/She was supposed to get it for 7 days, but the symptoms continued. When asked the date the medication was ordered, she stated, It was ordered 1/16/26 and he/she started taking it 1/17/26. When asked if the medication should have been administered today to Resident #43, she stated, Based on the order, he/she should not have received it. I guess it was an oversight because we should have gotten a new order. I'm going to call the doctor. The surveyor shared this was a concern with LPN #6 who acknowledged and confirmed understanding of the concern.2) On 2/25/26 at 8:18 AM LPN #10 was observed administering medications to Resident #57. During the administration, LPN #10 was observed preparing 2 tablets of Bumetanide 2mg and 1 tablet of Digoxin 125 mcg (micrograms). Review of Resident #57's medical record on 2/25/26 at 9:58 AM revealed the resident was also ordered and not observed receiving:Metoprolol Succinate Oral Tablet Extended Release 24 Hour 25 MG. Give 1 tablet by mouth one time a day for Heart failure at 9:00 AM.Menthol (Topical Analgesic) External Gel 4 %. Apply to skin topically two times a day for Pain at 9:00 AM.Skin Prep Spray Apply to bilateral heels two times a day for wound management at 9:00 AM. Diclofenac Sodium External Gel 1 %. Apply to left knee topically two times a day for pain at 9:00 AM. On 2/25/26 at 10:31 AM review of Resident #57's MAR revealed the Metoprolol, Menthol gel, and Diclofenac were documented with a check meaning Administered. Review of Resident #57's MAAR (Medication Administration Audit Report) revealed:Metoprolol with an Administration Time of 8:37AM and a Documented Time of 11:08 AM.Menthol gel with an Administration Time of 10:10 AM and a Documented Time of 10:10 AM.Skin Prep had no documentation for either Administration Time or Documented Time.Diclofenac gel with an Administration Time of 10:10 AM and a Documented Time of 10:10 AM. On 2/25/26 at 11:13 AM in an interview with LPN #10 when asked why the resident was not administered Metoprolol, LPN #10 stated, I didn't give it to him/her because his/her blood pressure and heart rate were low. When asked if she could read the Metoprolol order, LPN #10 opened the laptop on the medication cart, pulled up the order, and read it aloud. When asked if there were any parameters in the order, she stated, No, I don't see any parameters to hold the medication. When asked the facility's process when holding a medication, she stated, I'm supposed to notify the provider. When asked if she had notified the provider, she stated, No, I have not notified the provider. I am going to.During the interview when (continued on next page)

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked why the Menthol gel was not administered, LPN #10 stated, I didn't give it to him/her because I do ointments after the medications, so I don't mix them together. The surveyor asked to see the medication. LPN #10 went to the treatment cart, and the Menthol gel was not inside. She looked inside the medication cart, and it was not there. At that point LPN #10 said, We don't have it. I confused the name. I thought it was the Diclofenac. The nurse went into Resident #57's room and asked if she could see his/her creams. The Diclofenac was observed on the resident's bedside table, and the nurse picked it up. The nurse opened the drawers in the resident's bedside nightstand and was unable to locate the Menthol gel. After exiting the resident's room, the nurse said, I know he/she has 2 boxes and they're normally in his/her room. When asked if the medications were supposed to be stored in the resident's room, she said no. When asked if there was any other place the Menthol gel could be, LPN #10 stated, No, it's not here. I don't know where it is. The surveyor asked LPN #10 to pull up Resident #57's MAR (Medication Administration Record). A dual observation was conducted, and the Menthol gel was noted to be highlighted green. When asked what green meant, LPN #10 stated, I gave it. When asked how she could administer and sign off a medication as being administered that was not in the building, she said, It was a mistake.In addition, when asked why the skin prep spray was not administered, LPN #10 stated, Skin prep is in the morning and night and offered no further comments. On 2/25/26 at 12:28 PM in an interview with LPN #10, a dual observation of the MAR was conducted. The surveyor pointed out the Metoprolol with a check and initials [LPN#10's initials], which LPN #10 verified and confirmed. The surveyor and LPN #10 also observed in the key that a check mark meant the medication was Administered. When asked why the medication was signed off when LPN #10 had verified that it was not given, LPN #10 said, I should've clicked no. That was a mistake. Let me see if I can fix it. After surveyor intervention, LPN #10 changed the check mark in the MAR for the Metoprolol medication to a 7. When asked what that meant, she stated, To see a note. The surveyor shared these were concerns to LPN #10 who acknowledged and confirmed understanding of the concerns.3) An observation of medication administration on 2/25/26 at 8:30 AM showed that the Certified Medicine Assistant (CMA #11) prepared and administered 10 medications to Resident #70. Prior to putting each medication in the medication cup, CMA #11 verbalized the medication name, dose, and quantity and then handed the surveyor the medication package/container. Then, immediately before entering the resident's room, when asked how many total pills he was administering and to confirm the time, he first moved the pills from one medication cup to another to count and stated, 11 total pills and it's 8:43 AM. One of the pills dispensed and administered to Resident #70 was 1 tablet of Venlafaxine 25mg by mouth.Following the medication administration, a review of Resident #70's medical record revealed:Venlafaxine Tablet 25mg. Give 0.5 tablet by mouth one time a day for depression; however, 1 whole tablet was verbally stated by CMA #11 to the surveyor as it was being prepared. Furthermore, 1 whole tablet was what was observed being prepared and dispensed into the medication cup and then subsequently administered to Resident #70. Miralax Oral Powder 17gm (grams)/scoop (Polyethylene Glycol 3350). Give 1 scoop by mouth one time a day for bowel regimen mix in 4oz's (ounces) of water; stir well until dissolved. Jardiance Oral Tablet 10mg. Give 1 tablet by mouth one time a day for Diabetes. The medication was recorded as given on 2/25/26 at 8:45 AM; however, the surveyor did not observe CMA #11 preparing Jardiance, nor did CMA #11 report Jardiance as one of the medication he was preparing, and the surveyor did not observe Jardiance being administered. Salonpas Pain Relieving External Patch 4 % (Lidocaine). Apply to bilateral knees topically every 12 hours for bilateral knee pain. Eye Drops Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium). Instill 1 unit in both eyes two times a day for eye irritation place one drop in each eye.Sodium Fluoride Dental Paste 1.1 % (Sodium Fluoride Dental). 1 application dental two times a day for oral care.However, the surveyor did not observe medications Miralix, Jardiance, Salonpas, eye drops or Sodium Fluoride Dentals paste being prepared, nor did CMA #11 verbalize these medications as ones being administered, nor did the surveyor observe these medications being administered to Resident #70.On 2/25/26 at 11:41 AM in an (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview with CMA #11, the surveyor asked to see all of Resident #70's Venlafaxine. CMA #11 opened the medication cart and pulled out 2 blister packs of Venlafaxine. The blister packs only had whole tablets inside of the packs which CMA #11 confirmed. When asked if he could read the Venlafaxine order, CMA #11 opened the laptop on the medication cart and read it aloud. When asked how many tablets the order said to administer, CMA #11 stated, 1/2 tablet. When asked how much he administered, he said, A whole one. I got to have a talk about that. That was a mistake. There's no other way to say it. During the interview when asked why Resident #70 did not receive his/her Jardiance, he stated, He/She got that this morning when we went in with the pills. The surveyor asked CMA #11 to see the package for the Jardiance. He opened the medication cart and pulled out several blister packs of medications; however, he was unable to produce a package of Jardiance for Resident #70. As this point, the surveyor shared that he had told the surveyor each medication he was going to administer along with the dose and quantity and then handed the medication to the surveyor to observe and that Jardiance was not mentioned by CMA #11 nor Jardiance package observed nor Jardiance observed being dispensed or administered. During the interview, when asked if he is supposed to reorder medication when it gets low, he stated, I think I did the other day, but stuff doesn't come here on time from the pharmacy. In a dual observation, both surveyor and CMA #11 observed on his laptop, the date the medication was last ordered was 1/20/26. CMA #11 verified and confirmed, No, there's no more of this medication. When asked if the medication was signed off as administered, CMA #11 said, Yes, because sometimes we have to borrow from another resident's blister pack. When asked if that was something he was supposed to do, CMA #11 stated no and shook his head. When asked how Jardiance could have been administered when the Resident did not have any Jardiance, he offered no further comments. When asked why Resident #70 did not receive Miralax, CMA #11 stated, She took it in her water. The surveyor stated that he did not verbalize or show the surveyor Miralax during the medication administration, nor did the surveyor observe Miralax being prepared or administered. CMA #11 stated, That was in the water later. About 10-15 minutes ago I did her knee pads and gave him/her the Miralax. When asked why Resident #70 did not receive eye drops, CMA #11 stated, Sometimes I do them after.When asked why Resident #70 did not receive either fluoride treatment, CMA #11 stated, It's no particular reason. The surveyor shared these were all concerns to CMA #11 who verbalized and acknowledged understanding of the concerns.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure that the Ombudsman was notified of resident transfers to the hospital. This deficient practice was evident for 1 (Resident #104) of 1 resident reviewed for hospitalization notification during the recertification survey.The findings include:On 02/26/2026 at 11:40 AM, review of the electronic medical record for Resident #104 revealed that the resident was transferred to the hospital for emergent care on 12/03/2025 and was admitted , returning to the facility on [DATE]. Further review revealed that Resident #104 was transferred again to the hospital on [DATE] and returned to the facility on [DATE].On 02/26/2026 at 12:54 PM, the surveyor requested that the Nursing Home Administrator (NHA) provide documentation of notification to the Ombudsman regarding resident transfers and discharges.At 1:03 PM, review of the facility's list of residents sent to the Ombudsman revealed that Resident #104 was not included.At 1:06 PM, the surveyor notified the NHA that Resident #104, who had two hospitalizations in December 2025, was not listed on the notification provided to the Ombudsman.On 02/26/2026 at 1:24 PM, the facility provided a revised list of residents sent out to the hospital, which included Resident #104, indicating it would be submitted to the Ombudsman to correct the omission.At 1:33 PM, the NHA confirmed that the updated list, including Resident #104, was sent to the Ombudsman. The reason Resident #104 was not included on the original notification list was unclear.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints and residents' medical records, as well as resident, family, and staff interviews, it was determined that the facility failed to ensure dependent residents received necessary activities of daily living (ADL) care, including timely incontinence care, provision of scheduled showers, documentation of care, and provision of oral care as ordered. This was evident for 3 (Residents #17, #116, and #119) of 5 residents reviewed for ADL care during the complaint and annual survey.The findings include: Activities of Daily Living (ADLs) are the basic, essential self-care tasks people need to perform to maintain their health, safety, and well-being, such as bathing, dressing, eating, and toileting. Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents (regardless of payer) of long-term care facilities certified to participate in Medicare or Medicaid. 1.) On 02/24/2026 at 10:34 AM the surveyor interviewed Resident #17. During the interview, the surveyor observed a brownish plaque-like substance on the resident's upper and lower teeth. The resident reported that he/she does not receive help with oral care and wants their teeth brushed. On 02/26/2026 at 7:53 AM the surveyor conducted a review of Resident #17's medical records. The review revealed a physician's order dated 11/22/2025 for the resident to receive oral care two times a day. Further review of Resident #17's medical record revealed a Minimum Data Set (MDS) admission assessment dated [DATE] that coded the resident as being dependent for oral care. On 2/24/2026 at 8:14 AM the surveyor and Registered Nurse, RN #13, visited Resident #17 in his/her room. The surveyor asked the resident if he/had received oral care provided and s/he shook his head no. The surveyor observed brownish plaque-like pasty substance on the resident's upper and lower teeth. RN #13 stated that she will ensure Resident #17 receives oral care immediately. The DON and NHA were made aware of this concern on 2/26/2026 at 12:45 PM. 2.) During a complaint investigation, it was discovered that Resident #116 was not receiving timely cleaning and changing of their incontinence briefs, as well as changing of any wet or soiled bed linen. The resident's family member was interviewed via phone on 3/2/2026 at 11:44 AM where they reported that they had been with the resident around the clock during their 5 day stay at the facility. The family member stated that the resident had on a number of occasions used the call bell to get assistance in being changed and that the staff was either slow to come, taking 10 to 30 minutes or did not come at all. The family member stated that they would have to go to the nurse's station and request or demand assistance before they were able to get the resident the help they needed. The family member reported that when they spoke to the unit manager about the concerns they had regarding the resident being changed, the family member stated that they were told that the nursing staff changed the residents every 2 hours. In reviewing the medical record it was noted that incontinence care was only documented as being done once per shift. On 3/2/2026, at 12:45 pm the Director of Nursing was interviewed where they (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that that was how it was charted. 3.) Complaint 325579 was reviewed on 2/27/26 at 10:08 AM. The review revealed the complainant said Resident #119 was found many times on the weekend lying in urine, completely wet, and was not being cleaned. Resident #119's medical record was reviewed on 2/24/26 at 1:54 PM. The review revealed he/she was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, nontraumatic intracerebral hemorrhage, cognitive communication deficits, urinary tract infection, muscle weakness (generalized), and difficulty in walking. Further review of the medical record revealed the MDS dated [DATE] coded the resident as Dependent for Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement and Dependent for Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. In the MDS, Dependent was defined as Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. On 2/27/26 3:03 PM review of the medical record revealed on the Documentation Survey Report, Patient shower day is Tuesday and Friday 7-3. Please ensure shower sheet is completed. On 2/27/26 3:22 PM the surveyor requested to the Director of Nursing (DON) any and all shower sheets and/or any related documentation for Resident #119. On 3/2/26 at 8:57 AM review of the documentation provided revealed 3 shower sheets for Resident #119 dated: 3/25/25, 4/18/25, and 5/30/25. On 3/2/26 at 9:50 AM in an interview with the DON, a dual observation of the 3 shower sheets provided was conducted. When asked if Resident #119 had only received 3 showers in his/her almost 3.5 months here, she stated, Those are the only ones I could find. The surveyor shared this was a concern and the DON verbalized understanding of the concern. During the interview when asked how staff document when a resident's incontinence brief had been changed, she stated on the Kardex under Bladder documentation and they document Q shift. A dual observation of the Documentation Survey Reports for April-June 2025 was conducted. The DON was asked if she could confirm by looking at the medical record that Resident #119 was provided with incontinence care on the days there was no documentation for the shift. She verbalized she was unable to. The surveyor shared the concerns that Resident #119 was not provided incontinence care for 17 out of 90 shifts (19% of the shifts) for April 2025, 19 out of 90 shifts (21% of the shifts) for May 2025, and 5 out of 37 shifts (14 % of the shifts) for June 2025. On 3/2/26 at 9:56 AM the surveyor made a second request for any additional shower/bathing related documentation for Resident #119 from his/her admission to discharge. On 3/2/26 at 10:17 AM review of Resident #119's medical record failed to reveal that the resident was receiving his/her scheduled showers. On 3/2/26 at 11:24 AM in an interview with the DON when asked if the expectation for staff was to follow what the Kardex said to do for each resident, she stated, Yes, the GNAs (Geriatric Nursing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistants) should be completing whatever is listed on the Kardex. Additionally, the surveyor showed the DON Resident #119's April 2025 Documentation Survey Report and asked what NA meant [for showers]. The DON stated, NA means it wasn't done, but they [facility staff] still should have done a shower sheet. The DON was asked if she could confirm by looking at the medical record that Resident #119 was provided with showers on the days there was no documentation for the shift. She verbalized she was unable to. The surveyor shared the concern that 2 out of 7 showers (28%) were not provided in March 2025, 3 out of 9 (33%) showers were not provided in April 2025 and May 2025; and 1 out of 3 (33%) showers were not provided in June 2025. Furthermore, the surveyor shared the concern that the Kardex stated, Patient shower day is Tuesday and Friday 7-3. Please ensure shower sheet is completed. However, there were no corresponding shower sheets for the following dates: 3/7/25, 3/11/25, 3/14/25, 3/18/25, 3/21/25, 3/28/25, 4/1/25, 4/4/25, 4/8/25, 4/11/25, 4/15/25, 4/22/25, 4/25/25, 4/29/25, 5/2/25, 5/6/25, 5/9/25, 5/13/25, 5/16/25, 5/20/25, 5/23/25, or 5/27/25. The DON acknowledged understanding of the concerns.

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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. Based on surveyor observations, medical record review and staff interviews, it was determined that the facility failed to provide adequate care to prevent complications from hand contractures. This was evident for 1 resident (Resident #17) reviewed for mobility. The findings include: A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand.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.On 02/24/2026 at 10:34 AM the surveyor observed Resident #17's right arm and hand were contracted without a device in place. When asked if s/he usually had a splint or devices placed daily in his/her right hand. The resident responded by shaking his/her head, no.A record review on 02/26/2026 6:50 AM revealed the resident was diagnosed with contracture of the right wrist and right elbow on 04/04/2024. Review of the physician's orders showed Right carrot splint: Apply at 12 midnight and leave on 8 hours as tolerated; requires frequent adjustment. A carrot splint is a soft cone shaped device used to gently open, position, and treat severe hand contractures, preventing finger-to-palm skin breakdown, moisture build up and potential nail punctures. Further review into the medical record showed a care plan identifying that Resident #17 has an alteration in musculoskeletal status related to contractures and to assist the resident with use of supportive devices (carrot splints) as recommended.An additional observation on 02/26/2026 at 7:10 AM revealed no splint on Resident #17's right upper extremity. When the surveyor asked if he had a device in his/her right hand overnight, the resident shook his/her head, no.On 02/26/2026 at 8:14 AM, an interview with RN #13 while conducting observations in Resident #17's room, the surveyor asked if the resident usually wears a splint and RN #13 responded, I do not know, but I will request one.An interview 02/26/2026 at 8:22 AM with the Director of Rehabilitation (DOR) revealed that she brought up a new carrot splint for Resident #17. The surveyor observed the DOR place it into the palm of Resident #17's right hand.The Director of Nursing (DON) was made aware of these findings on 02/26/2026 at 8:45 AM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, staff interviews, and review of facility investigation documents, it was determined that the facility failed to provide adequate supervision to a resident as evidenced by Resident #27 eloping from the facility through the front door. This was evident in one of one resident reviewed during this survey. The findings include: During a review of the Medical Record and the facility's incident report on 2/26/2026 at 2:00 pm, it was discovered that on August 2, 2025, at 8:35 PM, Resident #27 left the facility through the front door by following Employee # 36 who was leaving for the day. The resident was found by a police who found them wandering in an adjacent parking lot. The Police Officer brought them back to the facility between 9:10 and 9:15 after verifying with Employee #35, who was outside of the building on break, that the resident lived at the facility. The facility staff had last seen her at 8:30 PM when the resident received their medication and was unaware that they were missing until the police brought them back. The resident had a wanderguard on their left ankle at the time of the elopement, but Employee #36 had disabled the alarm so that they could exit the building. Employee #36 stated in the interview during the facility investigation that they believed that the resident was a visitor and had had a brief conversation with the resident who then walked to the parking lot like they were going to their car.Upon the resident's return to the facility, a head to toe assessment was performed and no injuries were found. Their wanderguard system was tested and found to be on and functioning and the alarm sounded during the testing. During the facility investigation, interviews were conducted with Employee #34, the supervisor on duty, Employee #36 and Employee #35.Following this incident the facility had more security cameras installed and had the wanderguard alarm separated from the regular door opening alarm. The facility also educated the staff on elopement prevention and alarm response. The resident's elopement assessment was updated to increase the risk of elopement level to high. The resident had an elopement/wandering element on their care plan prior to this incident that included checking the wanderguard for placement and function, though the surveyor could not find any documentation that these checks were being performed.On February 26,2026 at 2:40 pm, the administrator was interviewed and verified that the information in the facility incident report was accurate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview with facility staff and observations, it was determined that the facility failed to store all drugs and biologicals in locked compartments. This was evident for 1 (Resident #57) out of 4 residents observed during the medication administration facility task for the recertification survey. The findings include:During a medication administration observation that took place on 2/25/26 at 8:18 AM, the surveyor observed Licensed Practical Nurse (LPN #10) prepare and administer 2 medications to Resident #57. Following the medication administration, a review of Resident #57's medical record on 2/25/26 at 9:58 AM revealed the resident was also ordered and not observed receiving: Menthol (Topical Analgesic) External Gel 4 %. Apply to skin topically two times a day for Pain at 9:00 AM and Diclofenac Sodium External Gel 1 %. Apply to left knee topically two times a day for pain at 9:00 AM. On 2/25/26 at 11:13 AM in an interview with LPN #10 when asked why the Menthol gel was not administered, LPN #10 stated, I didn't give it to him/her because I do ointments after the medications, so I don't mix them together. The surveyor asked to see the medication. LPN #10 went to the treatment cart, and the Menthol gel was not inside. She looked inside the medication cart, and it was not there. At that point LPN #10 said, We don't have it. I confused the name. I thought it was the Diclofenac. The nurse went into Resident #57's room and asked if she could see his/her creams. The Diclofenac was observed on the resident's bedside table, and the nurse picked it up. The nurse opened the drawers in the resident's bedside nightstand and was unable to locate the Menthol gel. After exiting the resident's room, the nurse said, I know he/she has 2 boxes and they're normally in his/her room. When asked if the medications were supposed to be stored in the resident's room, she said, No, but if it's left in the cart, sometimes it's not there and we have to look for it. The surveyor shared this was a concern. LPN #10 acknowledged understanding of the concern.On 2/25/26 at 2:06 PM in an interview with the Director of Nursing (DON) when asked if medications should be stored at the bedside, she stated no. The surveyor shared the concern that during the medication administration observation there were medications found at the bedside. The DON acknowledged the concerns and offered no further comments at that time.On 2/27/26 at 9:49 AM review of the facility's Medication Storage policy revealed, All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.

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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 with residents, observations, review of pertinent documentation, and interview with facility staff, it was determined that the facility failed to serve meals according to the predetermined menu and have a system in place to ensure alternative foods and beverages were provided for residents with allergies. This was evident for 1 (Resident #6) out of 3 residents reviewed for food during the facility's recertification survey.The findings include:On 2/24/26 at 8:35 AM in an interview with Resident #6, he/she stated, I think the food is deficient. For breakfast, I got a piece of bread and dry cereal. I had to ask for milk and coffee. During the interview he/she stated that every morning he/she drinks a cup of coffee, but he/she must ask for the coffee. Furthermore, he/she stated they think he/she has a milk allergy, but that he/she was not allergic to milk, it is just that if he/she drinks a whole container, he/she will have loose bowels. When asked if staff ask or asked him/her what they want to eat, he/she stated, They have a menu and they do it themselves. No, they never ask me what I want. I prefer orange juice. Orange juice was on the menu. I got this reddish drink. The surveyor observed a small amount of a clear, reddish beverage in the resident's cup on his/her tray. Also observed was the resident's meal ticket which had listed: Cold cereal of choice, biscuit, jelly, margarine, coffee or hot tea, orange juice and a dairy allergen listed. A medical record review on 2/24/26 at 12:12 PM showed that Resident #6 was originally admitted to the facility in June 2025 and able to communicate needs verbally. On 2/26/26 at 9:16 AM in an interview with Resident #6 when asked what he/she had for breakfast this morning, he/she said a piece of meat that looked like a hamburger and dry cereal. During the interview he/she stated that he/she had to ask for milk and coffee again because they do not bring it. Resident #6 stated, I have to remind them to give me coffee. I have to ask to get coffee even though I drink it every morning and have told them. He/She also stated that he/she did not receive orange juice and got a brown liquid that was maybe tea. On 2/26/26 at 3:08 PM in an interview with the Kitchen Manager (KM #24), when asked what week menu the facility was on, she stated, We are in in Week 4. On 2/26/26 at 3:10 PM review of the Week 4 menu revealed on Tuesday, 2/24/26, breakfast was scrambled eggs with cheese, oatmeal cereal, cold cereal of choice, biscuit, margarine, jelly, milk, coffee or hot tea, and orange juice. Further review revealed Thursday's breakfast menu was buttermilk pancakes, margarine, syrup, sausage patty, oatmeal cereal, cold cereal of choice, milk, coffee or hot tea, and orange juice. On 2/26/26 at 3:19 PM in an interview with KM #24 she stated, Everyone gets the regular meal unless they have a dislike or allergy and then they get the alternate. When asked if the food delivered should match the menu, she stated, Yes. During the interview, a dual observation of Resident #6's meal ticket from 2/24/26 and 2/26/26 and the Week 4 menu was conducted. For Tuesday, 2/24/26, the breakfast menu included scrambled eggs with cheese and orange juice; however, the resident's tray ticket nor breakfast tray included these food items nor did he/she receive the alternate. For Thursday, 2/26/26, the breakfast menu included buttermilk pancakes and orange juice; however, the resident's meal ticket nor breakfast tray included these food items nor did he/she receive the alternate. The surveyor shared the concern that for 2 out of 2 breakfast observations, Resident #6 did not receive what was on the menu. When asked why the meal delivered did not match what was on the menu, KM #24 stated, I can't say. KM #24 then stated it was probably because buttermilk pancakes have buttermilk and the resident has a milk allergy. When asked why Resident #6 did not receive an alternate breakfast, she stated, There was no alternate typed in. The system doesn't default to anything in place of the regular meal, but we can surely put something in there. When asked if the facility had milk alternatives such as almond milk, soy milk, oat milk, et cetera, KM #24 replied yes. When asked why Resident #6 did not receive an alternate milk, she said she did not know. The surveyor shared these were concerns and KM #24 acknowledged understanding of the 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, facility protocol, and staff interviews, it was determined that the kitchen failed to store food items so as to maintain the integrity of the specific item and failed to ensure that the nourishment refrigerators were maintained at the appropriate temperature. This was evident by the initial tour of the kitchen and the nourishment refrigerators.The findings include: 1. During the initial tour of the kitchen on 2/24/2026 at 8:10 am with Employee #39 it was discovered that a box of sausage patties in the freezer was open and the plastic bag holding the sausage was pulled completely back exposing the sausage to the environment. Employee #39 was made aware of the concern and disposed of the sausage.2. On 2/25/2026 at 2:54 pm during a temperature check of the nourishment refrigerators on the units, it was discovered that the refrigerator on the 2nd floor unit was registering a temperature of 52 degrees. The Regional Food Service Manager was notified, and they had all of the food in the refrigerator disposed of and stated that they would monitor the refrigerator and either repair or replace it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to keep complete and up to date medical records. This was found to be evident in 1 (Resident #80) of 41 residents reviewed during the annual survey.The findings include:A Kardex is primarily a nursing documentation system used for quick reference to patient care information. Its purpose is to streamline shift handoffs and provide a snapshot of daily care tasks. The facility used electronic Kardex (e-Kardex) modules integrated into the electronic health record (EHR).During an interview on 2/25/2026 at 8:56 AM, Resident #80 in room [ROOM NUMBER]-B stated to surveyor that they had not been showered by staff since they were admitted to the facility on [DATE]. Resident #80 was admitted to rehabilitation services at the facility after receiving a left hemiarthroplasty at an acute care hospital.A medical record review on 2/25/2026 at 11:05 AM revealed one documented bed bath in Resident #80's Kardex on 2/21/2026. No other documentation about showers or bed baths was found in the EHR. Additionally, there were no active medical orders in the EHR for Resident #80 to receive bathing/shower services or an order to not shower if contraindicated.On 2/25/2026 at 12:47 PM, the shower/bed bath log binder (hard chart) was reviewed on Resident #80's unit (Chesapeake). It contained a shower/bed bath schedule for the unit, which room [ROOM NUMBER]-B was to receive on Tuesdays and Fridays. There was no documentation in the binder for Resident #80 that they had received a shower or bed bath on those days since admission.On 2/25/2026 at 12:59 PM, Registered Nurse (RN) #9 was interviewed and stated the resident showering/bathing schedules are based on resident room numbers and the shower log binder contains a form that is filled out when residents receive showers/bed baths that includes a skin assessment, if the resident received a shower or bed bath, or if the resident refused. RN #9 stated it is expected that these forms are filled out and placed in shower/bed bath binder, as well as documented in the EHR. RN #9 reviewed the shower binder and Resident #80's EHR and confirmed the only documentation for shower/bed bath was in the EHR for 2/21/2026.The Director of Nursing (DON) stated during an interview on 2/25/2026 at 2:14 PM that it is the facility's expectation that all shower/bed baths are forms are documented in the shower/bed bath binder and the Kardex. The DON acknowledged surveyor concern of lack of documentation.On 2/25/2026 at 2:50 PM, the DON provided paper documentation of the shower/bad bath sheet which documented that Resident #80 refused a shower/bed bath on 2/25/2026.On 2/26/2026 at 3:00 PM, RN #9 showed surveyor an updated Kardex with stated Shower patient every Tuesdays and Fridays 7-3 shifts, ensure shower sheet is signed by nurse. Record review showed that the Kardex had been updated with this intervention on 2/25/2026.On 2/25/2026 at 3:10 PM, the DON provided shower/bed bath paper sheets dated 2/10/2026 and 2/17/2026 that stated Resident # 80 had received bed baths on those dates and refused showers. The DON could not answer why these forms were not in the shower/bed bath binder when surveyor reviewed previously. The DON also provided an email dated 2/25/2026 between the facility and Resident 80's orthopedist office that stated the office preferred patients do not shower until their post-operative appointment.On 2/26/2026 at 9:45 AM, a review of Resident 80's EHR revealed an order placed on 2/25/2026 at 8:01 PM that stated, SHOWERING RESTRICTION: Patient may not take a shower per orthopedics at John Hopkins Hospital until post op appointment (post discharge).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, it was determined that the facility failed to ensure oxygen tubing and humidifier bottles were dated to reflect appropriate change and monitoring in accordance with infection control practices. This deficient practice was evident for 2 (Residents #43 and #60) of 3 residents reviewed for oxygen use.The findings include: 1. On 2/24/26 at 7:53 AM, observation revealed Resident #43 was receiving oxygen therapy with a humidifier bottle attached; however, the bottle and the oxygen tubing were not dated to indicate when it had been placed in use. Staff #6 was notified at 7:55 AM and accompanied the surveyor to the resident's room. Staff #6 confirmed there was no date present on the humidifier bottle or the oxygen tubing. A new humidifier bottle and oxygen tubing were obtained and replaced at that time.2. On 2/24/26 at 8:04 AM, observation revealed Resident #60 was receiving oxygen therapy with oxygen tubing and a humidifier bottle attached that were also not dated. Staff #7 was notified at 8:06 AM and confirmed the absence of a date on the bottle and tubing. The issue was resolved at that time with replacement of the oxygen tubing and humidifier bottle.The Director of Nursing was informed of the findings on 2/24/26 at 12:47pm.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on surveyor observations, medical record review and facility staff interviews, it was determined that the facility failed to ensure residents had access to a call device system. This was evident for 2 of 2 resident room observations and 1 of 1 shower room observations. The findings include: 1. On 02/24/2026 at 10:34 AM, 02/26/2026 at 6:50 AM and at 8:14 AM Resident #17's call bell device was observed out of the resident's reach (entangled on the headboard).02/26/2026 8:14 AM Interview with RN#13 was conducted while in Resident #17's room. RN #17 nurse located the resident's call bell device entangled behind the resident's headboard. RN #13 untangled the call bell device from being wrapped around the headboard and placed it near the resident's left hand.A review of the resident's medical record revealed that Resident # 17 is totally dependent for all care and bed mobility with contractures to his/her right upper extremity and right sided paralysis. 2. On 02/27/26 at 7:15 AM an observation of a shower room on the [NAME] Unit revealed 1 of 3 shower bays without adequate length call device activation cord. This observation was made with the unit manager, UM #37.On 2/27/2026 12:05 PM the Nursing Home Administrator (NHA) was made aware of these concerns. The NHA confirmed the call device in the [NAME] shower room was replaced with a longer device cord.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to post complete and accurate daily nurse staffing information on each resident care unit, including the required staffing ratios for licensed nurses and nurse aides. This deficient practice was evident for 4 of 4 units reviewed (Chesapeake, Evergreen, [NAME], and [NAME]) during the recertification survey.The findings include:On 2/24/26 at 7:47 AM, during initial tour of the Chesapeake unit, observation of the staffing dry erase board revealed no staffing ratio was posted.On 2/24/26 at 7:50 AM, observation of the staffing board on the Evergreen unit revealed no staffing ratio was posted.On 2/24/26 at 7:59 AM, observation of the staffing board on the [NAME] unit revealed no staffing ratio was posted.On 2/24/26 at 8:06 AM, observation of the staffing board on the [NAME] unit revealed the board had not been filled out and did not include any staffing information or ratios.On 2/26/26 at 10:43 AM, follow-up observation of the Chesapeake unit staffing board again revealed no staffing ratio was posted.At 10:44 AM, observation of the Evergreen unit staffing board revealed an incomplete staffing ratio listing, which included licensed nurses only and did not include Geriatric Nursing Assistants (GNAs).At 10:47 AM, observation of the [NAME] unit staffing board revealed no staffing ratio was posted.At 10:48 AM, observation of the [NAME] unit staffing board revealed no staffing ratio was posted. At that time, the Director of Nursing (DON) was made aware of the findings. The DON immediately updated the [NAME] unit board and stated the remaining units with missing or incomplete staffing ratios would be corrected.On 3/2/26 at 1:06pm, the concerns were discussed with the Nursing home administrator during the exit conference.