STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215135	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Heritage LLC	7232 German Hill Road Dundalk, MD 21222

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 18819 Based on review of a facility reported incident, review of administrative and medical records, and staff interviews, it was determined that the facility failed to ensure a resident was free of a significant medication error when a nurse incorrectly administered the medication Methadone to a resident instead of the prescribed medication Methylphenidate. This was evident for 1 of 1 resident (Resident #1) reviewed for unnecessary medications during a complaint survey. The failure of the facility to ensure that Resident #1 was free of a significant medication error resulted in the determination of an immediate jeopardy situation being identified on February 25, 2025, at 6 PM. The findings include: Resident #1 was admitted to the facility after a brief hospital stay on 01/26/25 with diagnoses that included but were not limited to Narcolepsy, muscle weakness and recurrent falls. On 01/28/25, the plan for Resident #1 was to be discharged home. Review of facility reported incident #MD00214721 revealed Resident #1 received 100 milligrams of Methadone on 02/15/25 between 12 noon and 1 PM. Resident #1 should have received 20 milligrams of Methylphenidate which was prescribed for Narcolepsy. A review of the facility investigation on 02/24/25 at 3 PM revealed that RN#1 was performing treatments and then stopped and began administering medications. When RN#1 saw the letters M-E-T-H on Resident #1's MAR (medication administration record) RN#1 assumed the medication name was Methadone and administered a dose to Resident #1. It was not until about an hour later that RN#1 realized that he had given the wrong medication to Resident #1. RN#1 reported that he immediately assessed Resident #1 and stated that Resident #1 was sleepy, and his/her vital signs were stable. RN#1 then informed the nursing supervisor, RN#2, of the medication error. RN#2 instructed RN#1 how to complete the Change in Condition documentation, contact the on-call physician provider, and notify Resident #1's family. The third party physician service was notified of the error at this time. (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the facility's investigation revealed that RN#1 indicated that he did not compare the medication pulled from the cart (Methadone) to Resident #1's medication administration record and did not confirm the medication. RN#1 stated in the investigation that I was moving too fast and that he made an honest mistake. RN#1 indicated he saw the METH and assumed it was Methadone and administered the medication to Resident #1. RN#1 also indicated that he did not look at the bottle to see if was for Resident #1. RN#1 indicated that he did not check to see if the medication was in the correct form. Methylphenidate is prepared in a tablet (pill) and the Methadone that was administered to Resident #1 was in a liquid form. RN#1 indicated that he assumed the medication to be administered to Resident #1 was to be Methadone. In an interview with the third party physician service provider, CRNP#1, on 02/25/25 at 10 AM, CRNP#1 stated that she was on-call from 1 PM to 3 PM on 02/15/25. CRNP#1 stated that she received a telephone call on 02/15/25 at 2:14 PM regarding a medication error regarding Resident #1. CRNP#1 stated that during the a video telephone call she asked for the name of Resident #1 the date of birth which RN#1 could not provide. CRNP#1 stated she was informed that Resident #1 received a dose of another resident's Methadone in error. RN#1 was unable to provide CRNP#1 the exact dose of Methadone administered. CRNP#1 stated she was also informed the Methadone was located in the medication cart for a resident who had not been admitted to the facility. CRNP#1 stated she continued to ask RN#1 for the dose that was administered to Resident #1 but RN#1 was unable to inform her. CRNP#1 stated that she educated RN#1 on Methadone overdose and withdrawal signs and symptoms. CRNP#1 stated she confirmed that the facility had a supply of Narcan in the facility with RN#1. CRNP#1 stated that RN#1 informed her that Resident #1 was stable, in no distress, and that RN#1 would not administer Narcan to Resident #1 because Resident #1 had no symptoms of overdose. CRNP#1 asked for RN#1 to take the phone to Resident #1's bedside and was told by RN#1 that Resident #1 did not want to be bothered. CRNP#1 asked RN#1 to hold up the bottle of Methadone that was administered to Resident #1. CRNP#1 stated that RN#1 could not find the discarded bottle of Methadone administered to Resident #1 and held up a sealed unused container of Methadone to the camera. The sealed unused dose of Methadone was listed as having 100 milligrams in the bottle. CRNP#1 again asked RN#1 what was the dose of Methadone administered to Resident #1 and RN#1 stated that he did not know because he did not measure the dose of Methadone. RN#1 indicated that he could not find the empty bottle of Methadone administered to Resident #1. CRNP#1 was asked if she had access and if she reviewed Resident #1's electronic clinical record. CRNP#1 stated that she did not have access to Resident #1's clinical record due to the software not being the same. CRNP#1 stated that she relied on RN#1's information at the time of the call. CRNP#1 stated that RN#1 again informed her that Resident #1 was not symptomatic and stable. CRNP#1 stated that she did not think Resident #1 needed to be sent to the hospital at that time based on the report from RN#1. When asked, CRNP#1 stated that she did not call the facility back to check on Resident #1, did not speak with Resident #1's attending physician, and did not inform the oncoming CRNP of Resident #1's medication error after the phone call from the facility. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN #1 on 02/25/2025 at 2:22 PM, RN#1 stated that he was an agency nurse and that 02/15/25 day shift was the very first shift working in the facility. RN#1 stated that he became aware of administering Methadone to Resident #1 in error during the shift. RN#1 stated that he called the nursing supervisor and reported the medication error. The nursing supervisor instructed him to notify the medical provider and the family. RN#1 stated that he was not familiar with the facility procedure on how to notify the medical provider and had to go to the nursing office to receive assistance from the nursing supervisor to notify the medical provider. RN#1 stated that he received instructions to monitor Resident #1 frequently and notify the medical provider if there were any changes. When asked, RN#1 stated that he did not follow the 5 rights for administering medications to Resident #1 on 02/15/25. RN#1 stated that he was also heavily distracted during the medication pass on 02/15/25 when he incorrectly administered a dose of Methadone to Resident #1. Resident #1 was incorrectly administered a dose of Methadone at approximately 12 noon on 02/15/25. Resident #1 was found pulseless and without respirations by the nursing staff at approximately 9:50 PM on 02/15/25. Resident #1's death was reported to the Medical Examiners office. These failures resulted in an Immediate Jeopardy situation being identified on February 25, 2025 at 6 PM. The Maryland Office of Health Care Quality (OHCQ) determined that F 760 concerns, affecting Resident #1, met the Federal definition of Immediate Jeopardy and the facility was given the template and notified of this determination 02/25/25 at 6:00 PM. On 02/25/25 at 9:56 PM, the facility provided a plan to remove the immediacy while the surveyor was onsite. The removal plan was accepted by OHCQ at 9:56 PM on 02/25/25 and verified by the surveyor at that time. The abatement plan included: 1) Education of all nurses was initiated overnight on 02/15-02/16 on medication administration with focus on the six-rights medication administration, opioid management, and signs of opioid overdose, and in-house escalation protocol. All outstanding education will be completed prior to the next scheduled shift. 2) Medicine Pass evaluations and competencies will be completed for all licensed nurses. Each nurse will undergo a thorough assessment of their medication administration skills. Any identified areas for improvement will be addressed through additional training, and successful completion will be documented in the employee ' s personnel file. All medication evaluations will be completed prior to the next scheduled shift. 3) Staff will be quizzed on their understanding of the opioid overdose management policy post education. The quizzes will cover key topics, including recognizing the signs and symptoms of opioid overdose, appropriate response protocols, and steps for escalation. Results will be reviewed, and any areas of concern will be addressed through additional training or clarification. All quizzes will be completed prior to the next scheduled shift. 4) Nursing staff will be quizzed on their understanding of the medication administration policy post education. The quiz will focus on the rights of medication administration. Any knowledge gaps identified will be addressed through additional training and support. All quizzes will be completed prior to the next scheduled shift. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5) Ongoing monthly medication evaluations will be conducted for all licensed nurses and Certified Medicine Aides by DON/designee for the next 6 months. Each nurse will undergo a thorough assessment of their medication administration skills. Any identified areas for improvement will be addressed through additional training, and successful completion will be documented in the employee ' s personnel file. 6) The results will be reported by the DON to the Quality Assurance Performance Improvement Committee for at least six months or until 100% compliance is achieved. The alleged date of compliance is 02/25/2025. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents.