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	09/16/2025

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 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 observations, interviews, and a medical record review, it was determined that facility staff failed to provide personal hygiene services to totally dependent residents. This was evident in 2 (Residents #96 and #42) of the 5 residents reviewed for activities of daily living (ADL) care during the recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a standardized screening and assessment tool for the health status of all residents in long-term care facilities that are certified to participate in Medicare or Medicaid. 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. 1) During a phone interview on 9/08/25 at 9:53 AM. with Resident #96's responsible party, they reported that the resident had long toenails, and one had fallen off. On 9/10/25 at 11:23 AM, a surveyor observed Resident #96's toenail with Staff #21 (Registered Nurse). The toenail appeared yellowed, thickened, and misshapen. A review of Resident #96's MDS, dated [DATE], revealed that the resident was totally dependent on personal hygiene. During an interview on 9/10/25 at 10:51 AM, Staff #11 (Geriatric Nursing Aide) stated that they assess residents' ADL needs. While they provide and document nail trims when needed, they noted that toenail care is managed by nurses or doctors. Staff #3 (Educator) confirmed in a 9/10/25 interview at 12:06 PM that residents' toenails are managed by Podiatry. When the surveyor shared concerns about Resident #96, Staff #3 stated that the resident might have refused care. On 9/10/25 at 2:10 PM, Staff #3 confirmed that Resident #96 had not yet been seen by Podiatry. She noted that a consultation was placed on 9/09/25, only after the surveyor's intervention. 2) Complaint 333464 was reviewed on 9/10/25 at 8:39 AM. The review revealed the complainant stated Resident #42 had not received a shower in years and s/he loves showers. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/25 at 11:44 AM in an interview with the complainant s/he stated they do not give him/her a shower, that s/he had a layer of filth on his/her head, and [family member's name] had to scrape his/her head with a comb to try to get the dirt off. On 9/15/25 at 12:01 PM review of Resident #42's medical record revealed s/he was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, muscular dystrophy, Friedreich ataxia, and generalized muscle weakness. Further review of the medical record revealed the MDS [Minimum Data Set] dated 7/21/25 coded the resident as “dependent” for shower/bathe self and personal hygiene. Additionally, in section: GG0115. Functional Limitation in Range of Motion, Resident #42 was coded “2. Impairment on both sides” for his/her upper and lower extremities. The Documentation Survey Report from April 2025 through August 2025 was reviewed on 9/14/25 at 8:43 PM and revealed no documented showers or bed baths for Resident #42. Review of “Tasks: Shower/Bathing” on 9/15/25 at 11:26 AM and looking back 30 days (to 8/17/25) for “Question 1. Was shower given?” it was documented “No Data Found”. The answer choices to the question for facility staff to document were the following: “Yes”, “Resident Not Available”, “Resident Refused”, and “Not Applicable”; however, there were no dates listed, or responses documented for the dates of 8/17/25 through 9/15/25. On 9/9/25 at 7:55 AM in an interview with the Unit Manager (UM #1) when asked about showers, she stated that showers were offered 2 days a week for the residents. During the interview, she stated that Geriatric Nursing Assistants (GNAs) were responsible for providing the showers. When asked how the GNAs knew which residents were supposed to be showered, she stated a list was put on the assignment board and the GNAs have been trained and educated to look at the board to see which residents need to be showered. When asked if this was documented, she stated yes, on the shower papers and the POC's [In Point Click Care, the facility's electronic health record, POC stands for Point of Care. It refers to a feature or solution that enables healthcare staff to document resident care and other information in real-time, directly at or near the patient's location, using mobile devices, kiosks, or other digital tools. This system improves the accuracy and efficiency of documentation for things like activities of daily living (ADLs), vitals, and behaviors.] On 9/10/25 at 9:57 AM in an interview with UM #1, the surveyor asked to see the shower sheets for the year (2025) for Room [Resident #42's room number]. During a dual observation, the surveyor noted many shower lists with no date on the paper. When asked about the dates, UM #1 stated, yes, there should be a date written on the paper. When asked how it was identified who provided the shower, she stated by looking at the assignment sheet for the day. After looking through all the shower sheets in the folder, she provided the surveyor with two sheets for Room [Resident #42's room number] dated 6/25 and 7/16, which she confirmed were from 2025. On both dates, it was documented that the resident refused. When asked if there were any other places additional shower sheets might be, UM #1 stated, “No”. The surveyor shared this was a concern and UM #1 verbalized and acknowledged understanding of the concern. Resident #42's care plan was reviewed on 9/11/25 at 12:50 PM. The review revealed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: [Resident #42's name] is dependent for ADL [activities of daily living] care in: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Friedreich's ataxia, muscular dystrophy, limited mobility. Goal: Resident's ADL needs will be met: bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. On 9/15/25 at 7:34 AM the surveyor requested documentation of showers for Resident #42 from January 2025 to present. On 9/15/25 at 11:28 AM in an interview with the Nursing Home Administrator (NHA), he provided the Documentation Survey Reports from January 2025 to present and had highlighted “GG-Shower/Bathe Self”. The surveyor shared the concern that this section just documented the resident's ability to shower/bathe and not whether the resident actually received a shower. The NHA verified and confirmed there was no evidence the facility could provide that Resident #42 had been given a shower in 2025. The surveyor shared this was a concern and the NHA verified and confirmed understanding.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint intake, resident and staff interviews and record reviews, it was determined that the facility failed to provide quality of care services to their resident secondary to a delay in medication administration and wound treatments. This was evident for 2 (Residents #2, #174) of 37 residents reviewed for medication administration and wound treatment during the recertification/complaint survey.The findings include: 1) On 09/11/2025 at 2:39 PM review of a complaint incident #2580727 alleged that Resident #2's medications are given late and that this happens a lot. In an Interviews with Resident #2 on 9/9/25 at 9:30AM regarding late medication administration. The resident blamed it on the agency staff that the facility frequently uses and stated that his/her medications are given late most of the time. On 9/9/25 at 9:45 AM a review of the August 2025 Medication administration records (MAR) did confirm that numerous medications (Meds) were given 2-4 hours late on different days. For instance, on: 8/1/25: the 8:00 AM meds. Renvela and Ferrous sulphate was given at 11:22 AM 9/2/25: The 10:00 AM meds. Lidocaine patch and Jardiance were given at 16:33 PM 8/3/25: the 10:00 AM meds. Pregabalin and lidocaine patch were given at 12:58 PM 8/6/25: the 8:00 AM meds. Iron sulphate and Renvela were given at 12:50 PM 8/6/25: the 10:00 Am meds Keppra and senna were given at 13:02 PM 8/11/25: the 10:00 AM Metoprolol was given at 15:15 PM including some other medications. This late medication administration continued throughout the month of August. On 9/11/25 at 1:24 PM Staff #2 a Registered Nurse who was also contracted from the agency was asked in an interview to explain the policy for med administration. He said that medications should be given one hour before or one hour after the medication administration scheduled time. He was asked to explain some of the reasons why meds are given late. He stated that sometimes they are short staffed and have only 2 nurses available in their unit. Sometimes a medicine aide was not available to help, or an emergency could occur that could delay medication administration. He was asked what the major contributor was, and he said it's mostly from being short staffed. On 9/11/25 at 8:15 AM the Director of Nursing was made aware that meds are given late to the residents and that this was a concern. She explained that the facility was aware of the late medication pass and has recently changed the times meds are given on different units to help decrease the lateness issue. She was made aware that the lateness is still a concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Complaint 333453 was reviewed on 9/10/25 at 8:01 AM. The review revealed that the complainant stated that it took two days for the facility staff to clean or change the bandages for Resident #174's left foot wound. Additionally, the review revealed that the complainant said that it took two days for the resident to receive his/her IV [intravenous] antibiotic. On 9/15/25 at 10:01 AM review of Resident #174's medical record revealed s/he was admitted on [DATE]. Further review of the medical record revealed the following order: Wound: (L) plantar foot - cleanse wound with ns [normal saline], pack with silver alginate, cover with abd [abdominal gauze pad, used to absorb discharges from draining wounds] pad then wrap with kling [a stretchy gauze bandage that sticks to itself]. Every day shift for wound care AND as needed for wound care. This was ordered on 10/31/23. On 9/15/25 at 11:39 AM in an interview with the Director of Nursing (DON) the concern was shared that the resident's wound treatment was not cleaned or dressed until two days after his/her admission. During the interview, a dual observation of the resident's October TAR [Treatment Administration Record] the wound treatment order Resident #174's left foot wound was observed with an order date of 10/31/23. The surveyor shared the concern that this treatment was not ordered until two days after the resident was admitted to the facility. The DON acknowledged the concern and stated she would see if there was any additional documentation/evidence of earlier wound treatment. On 9/15/25 at 12:57 PM in an interview with the DON she stated she looked and there was no additional wound treatment order aside from the 10/31/23 order. The surveyor shared this was a concern and the DON confirmed understanding. On 9/15/25 at 12:59 PM review of Resident #174's physician orders and his/her October 2023 MAR revealed the following orders for IV antibiotics: - Vancomycin Intravenous Solution, order date: 10/29/23 12:00 PM. There were no doses documented as administered by nursing staff in the MAR [Medication Administration Record]. - Vancomycin Intravenous Solution, order date: 10/29/23 10:48 PM The first dose documented as administered by nursing staff in the October MAR was on 10/30/23. On 9/15/25 at 12:29 PM review of the Medication Administration Audit Report [MAAR] for Resident #174 revealed the IV vancomycin (antibiotic) was first scheduled for 10/30/2023 at 9:00 AM and first administered 10/30/2023 at 11:57 AM; however, the resident was admitted to the facility on [DATE] at 11:02 AM. On 9/15/25 at 2:27 PM in an interview with the NHA he stated there were no additional orders for the IV vancomycin aside from the one ordered a day after Resident #174's admission. The surveyor shared this a concern and the NHA acknowledged understanding.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on investigating complaints, medical record review, and staff interview it was determined that the facility failed to provide pain management timely. This was found to be evident for one (Resident #178) out of 10 residents reviewed for pain management during the recertification/complaint survey. The findings include: A complaint review on 09/11/25 at 9:00 AM showed that a complainant reported that Resident #178 experienced severe pain from approximately 9:00 PM on 05/12/24 until 10:20 AM on 05/13/24. The resident was reported to have cried and screamed in pain, but no pain assessment or medication was provided. On 9/11/25 at 9:57 AM, a review of Resident #178's medical records revealed that the resident was alert and oriented with a BIMS score of 15/15. A progress notes dated on 5/12/24 at 10:58 AM documented that the resident complained of bilateral leg pain with a pain level of 10/10, indicating severe pain. Additional progress noted dated 5/12/24 at 15:10 (3:10 PM) documented that “…MD ordered routine typenol 1000mg q 12 hrs and Tylenol 650 mg q 6 PRN (as needed), Tylenol 1000mg administered, lidocaine patch administered, resident repositioned. Approximately 10 mins after medications was administered, family visited.” The transfer form for Resident #178 was documented that he/she was transferred to the hospital on 5/12/24 at 4:30 PM. On 9/11/25 at 10:30 AM, review of the Medical Administration Record (MAR) showed no documentation to support that Tylenol was ever administered to the resident on 05/12/24 Additionally, there was no pain assessment documented in the medical record. On 09/10/25 at 10:33 AM, Staff #28 (Registered Nurse) stated that every resident is evaluated for pain every shift. This statement contradicts the lack of a documented pain assessment for Resident #178. The Director of Nursing (DON), interviewed on 09/11/25 at 11:50 AM, confirmed that if staff noted a resident's pain, it should be managed immediately and all medication administration must be documented in the MAR. The DON also confirmed that the five-hour gap between the initial documentation of pain at 10:58 AM and the resident's transfer to the hospital at 4:30 PM was a failure to address the resident's pain in a timely manner.