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	02/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility documentation and interviews, it was determined the facility staff failed to protect a resident from verbal abuse from facility staff (Resident #8). This was evident for 1 of 11 residents reviewed for abuse during a complaint survey. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 12/5/25. The findings include: Review on 2/24/26 of a facility reported incident that occurred on 11/29/25 revealed Staff #19 (geriatric nursing assistant) witnessed Staff #25 (licensed practical nurse) tell Resident #8 hit me you (expletive language), you not gonna do (expletive language), I will beat the (expletive language) out of you. Staff #19 notified Staff #20 (nursing supervisor) who responded to the situation and also witnessed Staff #25 tell Resident #8 he will beat (expletive language) out of you. Review of Resident #8's medical record on 2/24/26 revealed the Resident was admitted to the facility in 2025 and is alert and oriented. During interview with Staff #20 on 2/24/26 at 9:05 AM, Staff #20 stated he was the nursing supervisor on 11/29/25. Staff #20 stated he was notified by Staff #19 that she had heard Staff #25 call Resident #8 (expletive language) and that Staff #25 told the Resident he will beat (expletive language) out of him/her. Staff #20 stated he immediately approached Staff #25 and also heard what Staff #19 reported. Staff #20 stated Staff #25 was being abusive to Resident #8 and was afraid it was going to get physical. Staff #20 told Staff #25 he had to leave the facility, which Staff #25 initially refused to do but eventually did leave the facility when Staff #20 was calling the police. During interview with Staff #19 on 2/24/26 at 10:02 AM, Staff #19 stated Resident #8 approached the nursing station where Staff #19 was documenting and asked if Staff #19 would tell Staff #25 to stop coming into his/her room. Resident #8 stated, I ask him to leave the door closed but he keeps going back and forth with me. Staff #19 stated that she walked back with Resident #8 to his/her room and told Staff #25 what the Resident requested. Staff #19 stated Staff #25 said I don't care I am going back in and went in anyway, further stating I have to give his/her roommate their medications. Resident #8 kept telling Staff #25 to leave his/her room but Staff #25 refused so Resident #8 began yelling. Staff #19 kept telling Staff #25 to leave the room but he said you can't allow patients to talk to you like that. It became heated and Staff #25 and Resident #8 were talking to each other like they were on the streets. Staff #25 told Resident #8 he was going to beat (expletive language) out of him/her and they were both calling each other (expletive language). Once Staff #25 left the Resident's room and Staff #19 felt the Resident was safe I notified Staff #20. Staff #20 then told Staff #25 they had to leave the facility and Staff #19 saw Staff #25 leave. During interview with the Administrator on 2/24/26 at 9:45 AM, the Administrator stated the facility confirmed verbal abuse of Resident #8 by Staff #25 on 11/29/25. The Administrator stated we put a plan into place and completed the plan on 12/5/25. The Surveyor attempted to interview Resident #8 on 2/24/26 at (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:18 AM but the Resident stated he/she didn't want to talk about the incident anymore. The Surveyor reviewed the facility's plan on 2/24/26. The plan included: 1) Removal of Staff #25 pending investigation 2) Staff #25 reported to nursing agency with results of investigation 3) Staff #25 not allowed to return to facility 4) Staff #25 reported to Maryland Board of Nursing 5) Resident assessed by providers and social services 6) All staff were reeducated on abuse prohibition and mandatory reporting. 7) All interviewable residents in facility were interviewed for abuse. No residents reporting abuse. 8) All non-interviewable residents had skin assessments completed and no signs of abuse were identified. 9) An Ad-hoc QAPI (Quality Assurance Performance Improvement) meeting was held on 12/1/25. The Surveyor verified completion of the plan on 2/24/26.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined that facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 5 (#5, #4, #2, #1, #14) of 14 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.1) On 2/20/26 at 8:46 AM a review of Resident #5's medical record was conducted. Review of Resident #5's December 2025 Medication Administration Record (MAR) revealed the administration of Gabapentin every 8 hours for neuropathy. Gabapentin is classified as an anticonvulsant drug and is commonly used to treat nerve pain as well as partial seizures.Review of Resident #5's significant change MDS assessment with an assessment reference date (ARD) of 12/30/25, Section N0415 (High-Risk Drug Classes), failed to capture the anticonvulsant (Gabapentin). Review of Resident #5's MDS assessment with an ARD of 12/24/25, Section N0415 (High-Risk Drug Classes), also failed to capture the anticonvulsant (Gabapentin). On 2/24/26 at 11:21 AM an interview was conducted with the MDS Coordinator, Staff #28 who confirmed the error. Staff #28 stated that the primary MDS Coordinator had been out on leave and other people had been filling in doing the MDS assessments. 2) On 2/20/26 at 9:40 AM a review of Resident #4's medical record was conducted and revealed an 9/29/25 at 4:39 AM note that stated, resident found on the floor next to the resident's door in a sitting position. Review of Resident #4's MDS with an ARD of 9/25/25, Section J1800, any falls since admission/entry or reentry or prior assessment, documented 0 falls. The facility staff failed to capture the fall. On 2/24/26 at 11:21 AM the MDS Coordinator, Staff #28 confirmed that the fall was not captured. 3) On 2/20/26 at 10:48 AM a review of Resident #2's medical record was conducted. Review of Resident #2's MDS assessment with an ARD of 11/14/25, Section N0415 (High-Risk Drug Classes, captured the use of a hypoglycemic medication. Hypoglycemic medications are used to lower high blood sugar in people with type 2 diabetes. Review of Resident #2's November 2025 MAR did not document any hypoglycemic medications. Resident #2 did not receive hypoglycemic medications during that time. On 2/25/26 at 11:18 AM an interview was conducted with the MDS Coordinator who confirmed that Resident #2 was not on hypoglycemic medications and that was an error.4a) On 2/20/26 at 12:48 PM a review of Resident #1's medical record was conducted. Review of Resident #1's January 2026 MAR documented that Resident #1 received Lorazepam on 1/30/26 at 1:06 AM. Lorazepam is an antianxiety medication.Review of Resident #1's Discharge Return Not Anticipated MDS Assessment with an ARD of 1/31/26, Section N0415 (High-Risk Drug Classes), failed to capture the use of the antianxiety medication.4b) Review of Resident #1's vital sign section of the medical record documented the use of oxygen via nasal cannula.Review of Section O, Special Treatments, Procedures, and Programs, C1 Oxygen therapy was not coded. The facility failed to capture the use of oxygen.Continued review of Section O, Hospice Services, was checked off as received.Review of Section J1400 Prognosis, does the resident have a condition that may result in a life expectancy of less than 6 months? was coded, yes.On 2/25/26 at 11:21 AM an interview was conducted with Staff #28. Staff #28 stated that the resident did not receive Hospice services while at the facility, therefore that should not have been coded. Staff #28 also confirmed that there was no documentation from the physician that the resident had a life expectancy of less than 6 months. Staff #28 also confirmed the error regarding the Lorazepam. 5a) On 2/24/26 at 9:15 AM a review of Resident #14's medical record was conducted and revealed a 2/11/26 at 18:38 (6:38 PM) change in condition note that documented, aggressive/combative (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior.Review of a 2/11/26 at 20:21 (8:21 PM) change in condition form documented, behavioral symptoms - agitation, psychosis. Aggressive behavior, throwing stuff at staff, destroy facility property. The form stated, describe verbal aggression: 1. Aggression - throwing plates, stating [he/she] wants to hurt [her/himself].Review of the MDS assessment with an ARD of 2/11/26, Section E0200, Behavioral Symptom - Presence and Frequency, was coded 0 for physical behavioral symptoms directed toward others and 0 for verbal behavioral symptoms directed towards others. 5b) Continued review of Resident #14's medical record revealed Resident #14's February 2026 MAR documented Resident #14 received Gabapentin 3 times per day. Review of Resident #14's MDS assessment with an ARD of 2/11/26, Section N0415 (High-Risk Drug Classes), failed to capture the anticonvulsant (Gabapentin). On 2/25/26 at 11:21 AM an interview was conducted with the MDS Coordinator, Staff #28. Staff #28 confirmed that she did not see the behaviors on the form and that the Gabapentin was missed. Staff #28 stated that she made the Nursing Home Administrator and the Director of Nursing aware of the errors.

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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 staff and resident interviews, and record review the facility failed to give Resident #12 a shower on Tuesday and Friday as ordered for the month of January 2026 and February of 2026. This was evident for one (Resident #12) of 1 resident reviewed for ADLs during the complaint survey. The Findings Include: An interview was conducted with the responsible party (RP) of Resident #12 on 2/20/26 at approximately 2PM. The RP of Resident # 12 complained that the Resident has had no shower in the last 2 months. An interview was held with Resident #12 on 2/20/26 at 12:30PM who is alert and oriented and can make his/her needs known. Resident #12 also stated he/she has had no shower in the last 2 months and stated he/she wanted a shower. There was one time in [DATE] that the resident refused a shower/bed bath because he/she had diarrhea. The Surveyor reviewed the treatment and GNA (Geriatric Nursing Assistant) record and the documentation showed Resident # 12 has only received a bed bath, but not a shower. The resident is not opposed to a bed bath once in a while, however she/he should be offered a shower on his/her shower days and not a bed bath. The administrator was made aware of this on Friday 2/20/26 and said ok.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to administer medications as ordered by the physician (Resident #13). This was evident for 1 of 14 residents reviewed during a complaint survey.The findings include:Review of Resident #13's medical record on 2/24/26 revealed the Resident was admitted to the facility in December 2025 with a diagnosis to include acute prostatitis. Acute prostatitis is a sudden, severe bacterial infection of the prostate gland, often causing intense pain, fever, and urgent urinary symptoms. Review of Resident #13's hospital Discharge summary dated [DATE] revealed the Resident was ordered Ertapenem 1 gm intravenous antibiotic every day to end on 1/30/26. Review of Resident #13's January 2026 Medication Administration Record revealed the Resident did not receive Ertapenem on 1/30/26.Further review of Resident #13's physician ordered revealed the Resident's antibiotic was changed from Ertapenem to Meropenem 2 gm intravenous antibiotic every 8 hours on 2/4/26. Review of Resident #13's February 2026 Medication Administration Record revealed there is no evidence the Resident received Meropenem on 2/15/26 at 10:00 PM. Interview with the Director of Nursing on 2/25/26 at 8:30 AM confirmed the facility staff failed to administer antibiotic medication to Resident #13 on 1/30/26 and 2/15/26.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and interview, it was determined the facility failed to provide respiratory services in accordance with professional standards of practice (Resident #1 and #13). This was evident for 2 of 3 residents reviewed for respiratory services during a complaint survey. The findings include: 1) Review of Resident #13's medical record on 2/24/26 revealed the Resident was admitted to the facility in December 2025 with a diagnosis to include Obstructive sleep apnea. Obstructive sleep apnea (OSA) is a sleep disorder characterized by repeated episodes of complete (apnea) or partial (hypopnea) collapse of the upper airway, causing oxygen desaturation or sleep arousal. Review of Resident #13's hospital Discharge summary dated [DATE] revealed the Resident was to continue on BiPAP for sleep. BiPAP (Bilevel Positive Airway Pressure) is a noninvasive ventilation device used to treat breathing difficulties, such as sleep apnea, by delivering pressurized air through a mask. Review of Resident #13's December 2025 Treatment Administration Record revealed the BiPAP was not ordered and documented it was administered until 12/29/25, 3 days after admission. Interview with the Administrator on 2/24/26 at 2:00 PM confirmed the facility staff failed to administer the Resident's BiPAP for 3 nights after admission. 2) On 2/20/26 at 12:48 PM a review of Resident #1's medical record revealed Resident #1 was admitted to the facility in December 2025 with diagnoses that included but were not limited to COPD, asthma, and chronic myeloid leukemia. Review of a 12/13/25 system note documented that Resident #1 was receiving oxygen at 3 LPM (liters per minute) via nasal cannula. Review of a 12/16/25 history and physical documented the chief complaint for the visit included acute on chronic hypoxic hypercapnic respiratory failure. The note documented the resident had COPD and asthma and was on home oxygen of 2 to 3 liters. It was documented that while the resident was in the hospital prior to admission, Resident #1 had community-acquired pneumonia and acute hypoxic respiratory failure. Review of the vital sign section of Resident #1's electronic medical record documented intermittent use of oxygen. Review of Resident #1's December 2025 and January 2026 physician's orders failed to produce an order for oxygen therapy and orders for tubing changes, humidification, oxygen saturation goals, and basic care of the resident receiving oxygen therapy. Review of the oxygen therapy policy that was given to the surveyor by the Director of Nursing (DON) on 2/24/26 at 1:30 PM documented the procedure, 2. Verify medical doctor order (should include liter flow, type of O2 delivery device). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/26 at 1:30 PM an interview was conducted with the DON. The DON reviewed the vital sign section of the medical record where it was documented that Resident #1 received oxygen therapy. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) were reviewed with the DON who confirmed that there was no documentation of oxygen usage, the changing of oxygen tubing, and if humidification was used.