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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, it was determined that the facility failed to maintain a clean, sanitary and homelike environment for their residents. This was evident for 1) 1 of 2 nursing units in the facility and 2) observation of the laundry room during the recertification/complaint survey.The findings include:1) On 9/8/25 at 3:31PM during the initial rounding in the facility, the surveyor observed that the bathroom ceiling in room [ROOM NUMBER] was busted inwards where the water sprinkler was located about 10x4 inches long. Further observation of the ceiling on the second-floor hallway by the medication room and janitor's closet were three vents. All three were covered in dust and had multiple rusty brown colored stains plastered all over.On 9/10/25 at 8:55 AM, Staff #10, a maintenance director, in an interview, was asked if they round on the floors in the building and he said they do so daily. He was asked what they look out for during the rounds, and he said everything, mainly safety issues such as trip hazards, wheelchairs, doors not working properly, automatic closure on doors etc. He was asked if they checked the vents in the hallways and he said he had a painter paint one recently and placed an order for a new one for the kitchen. He was asked if their vents got cleaned at all. He said they don't have a scheduled cleaning of the vents.On 9/10/25 at 9:26AM the surveyor took Staff #10 up to the second floor and showed him the 3 rusty and dust covered vents including the bathroom ceiling in room [ROOM NUMBER]. He said that the vent has been painted many times and needed to be vacuumed, cleaned or replaced, and that the black spot was due to condensation from the cold air. He stated that staff put in a ticket for room [ROOM NUMBER]?s bathroom to have it replaced but was not sure when it was put in. Regarding room [ROOM NUMBER]'s bathroom, he said they are upgrading the bathrooms and will fix the ceiling too. He was made aware that it was a concern, he said he was the only maintenance in the building, and the facility is currently hiring.09/10/2025 10:01 AM the administrator was made aware of the concern2) On 9/12/25 at 9:30AM- Observation of the laundry room revealed that on the dirty side where dirty laundry is received and sorted, a large sink reserved for eye wash was very dirty and covered with brown stains, it was also leaking and had towels underneath to catch the leaks. Staff # 27, the housekeeping supervisor/Account manager, said she made Staff #10 the maintenance director aware of it about 2 weeks ago. She stated that one side was leaking and staff #10 came and fixed it and it worked for a while. She said it stopped working. At 11:05 AM the DON was made aware of the findings/concern, she said she will bring it to the attention of the maintenance director.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record reviews and staff interviews, it was determined that the facility failed to label oxygen (02) tubing with change dates. This was evident for 7 (#44, #127, #153, #149, #116, #76, #91) of 7 residents reviewed for respiratory care during the recertification/complaint survey.The findings include: A nasal cannula is a device that delivers oxygen directly to a person's nose through a flexible plastic tube that is attached to a piece of equipment that provides oxygen. The plastic tube can harbor bacteria and mold. It is important to change the tubing to prevent the spread of germs and to maintain health and safety during oxygen therapy. Staff should label the tube with a date to indicate when it had been changed. 1) On 9/8/25 at 8:30 AM during the initial rounding on the units, the following residents were noted to be on oxygen (O2) therapy: Resident #44, #127, #153 and #149. All 4 residents had their O2 tubing used to deliver O2 through the nose connected to a humidifier at the bedside but none of the O2 tubes were labelled with a date to indicate when it was last changed. In an interview with Resident #44 observed on 02 at 4 liters on 09/08/2025 at 8:39 AM, S/he was asked when their O2 tubing was last changed and s/he stated, they only change it when asked. Further review did not reveal a physician order to change the O2 tubing. Resident #127 has orders that read: Oxygen at 2L/min via Nasal Cannula, continuously. every shift. There was no order for tubing change. Resident #153 orders read: Oxygen at 3 L/min via Nasal Cannula continuous every shift. 10/27/23-Oxygen tubing, change weekly Label each component with date and initials, every day shift every Wed. Label each component with date and initials AND as needed. It was not labelled. Resident #149 orders read: Oxygen at 2 L/min via NC continuous every shift for COPD. 5/24/25: Oxygen humidifier bottle tubing, change weekly- Label each component with date and initials every day shift every Mon. Label each component with date and initials. It was not labelled. On 9/8/35 at 11:25 AM, Staff #33 a Registered Nurse, was asked in an interview who does the O2 tubing changes and she said it's done by day shift. She was asked how often, and she said she was not sure, but the frequency will be on the Medication/treatment administration records. She was asked when the O2 tubing was last changed and she said she did not know. She was asked if the tubing should be labeled with a change date and she said she did not know but will find out. On 9/8/25 at 11.31AM- Staff #33 came back to say that she asked her unit manager and was told that O2 tubes should be labelled with change dates. On 9/8/25 at 11:34AM Staff #28, the Unit Manager, in an interview was asked how often the O2 tubing should be changed, and she said it should be labelled and changed every 7 days. She was made aware that all residents on the 2nd floor on O2 did not have a label on their O2 tubes. She indicated that it had been brought to her attention, and she was addressing the issue with her staff. On 9/11/25 at 8:15 AM the Director of Nursing was made aware of the concerns, and she said she will follow up. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During the screening process of the survey on 09/08/2025 at 8:39 AM, surveyor observed the oxygen tubing did not have a label dated for Residents #116, #76, and #91. On 09/08/2025 at 12:02 PM during the investigative phase of the survey, surveyor observed Resident #116's oxygen concentrator and nasal tubing without a label, therefore, surveyor did not know when tubing was changed, and the resident was unsure of the last time tubing was changed. In an interview on 9/8/2025 at 12:25 AM, Staff # 33 stated that the oxygen tubing was to be changed on day shift but were not sure about how often. When asked if the tubing should be labeled, staff # 33 stated that she/he did not know but will find out. Staff # 33 returned and informed surveyor at 12:31AM that nasal cannula tubing should be labelled. An interview was conducted 9/8/2025 at 12:34AM with the Unit Manager (Staff # 28) who stated that the oxygen tubing should be changed every 7 days and was also supposed to be labelled. A review of Resident #116's medical record on 9/8/2025 at 11:40 AM revealed an order written on 2/17/2025 for Oxygen 2L/min via Nasal Cannula continuous every shift. There were no order for changing or labelling tubing. On 09/09/2025 at 2:17 PM, an interview was conducted with the Nurse Educator (Staff #3) who stated that the staff are now getting an Inservice on oxygen delivery and labeling of the tubing and oxygen equipment. When surveyor asked about the documentation for changing the oxygen delivery supplies, staff #3 stated that orders, care plan, and treatment records will be updated to capture the proper documentation. 09/11/2025 at 8:23 AM Surveyor informed DON that the oxygen tubing was not labeled and there were no orders or documentation for changing the oxygen tubing in Resident # 116's medical record. the DON acknowledged that this was a concern and stated that it will be corrected.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on a review of employee files and staff interviews, it was determined that the facility failed to implement a system to ensure newly hired Geriatric Nursing Assistants (GNAs) were competent in their skill sets. This deficiency was evident in four (GNA #15, # 17, 36, and #37) out of five GNA employee files reviewed during the recertification/complaint survey.Findings include:According to the American Nurses Association, nursing competence is an expected level of performance that combines knowledge, skills, abilities, and judgment.On 9/11/25 at 9:40 AM, a surveyor reviewed five randomly selected GNA employee files. The reviewed revealed four employees did not have records showing their competencies were verified upon hire: GNA #15 (hired March 2023), GNA #17 (hired December 2022), GNA #36 (hired September 2023), and GNA #37 (hired July 2024).During an interview on 9/11/25 at 2:05 PM, Staff #3 (an educator) confirmed that GNA skills are required to be verified before they can begin working on a unit. When the surveyor reviewed the files for GNAs #15, #17, #36, and #37 with Staff #3, she acknowledged that their competencies and skills had not been verified upon hire.The Director of Nursing (DON) was informed of these findings during an interview on 9/15/25 around 1:00 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and staff interviews, it was determined that the facility failed to process linen in such a manner as to prevent infection, evidence by staff not wearing a protective gown to sort dirty linens and having drinks and personal items on the clean folding table next to clean laundry. This was observed during the recertification/complaint survey.The findings include:On 9/12/25 at 9:30 AM an observation of the laundry room revealed 2 folding tables located to the left and right side of the room. On the clean folding table to the right was observed a large (20 oz) cup of ice coffee about 1/4 full lying on the table, a cell phone plugged in to an electric outlet charging on the table, 3 lunch bags, and a table fan with the blade cover removed and the blades covered in dust.On the clean folding table to the left was observed an open can of cold breeze berry energy drink about 3/4 full, a Remedy essential cleanse shampoo and body wash, an open packet of Twizzlers pull and peel candy (orange cream top), a lunch bag and a cell phone.In an interview with Staff #31 a laundry assistant on 9/12/25 at 9:35AM, she was asked if those items were supposed to be left on the clean laundry folding table and she said no, that she was sorry and proceeded to take them away. The surveyor then entered the dirty side of the laundry room where laundry is sorted and found Staff #32 (laundry aide) sorting dirty linens. The laundry aide had a glove and mask on; the mask was pulled down underneath her nose exposing it. She was not wearing a protective gown. Hanging on a peg were 3 yellow gowns and a pack of gloves was in a corner.In an interview on 9/12/25 at 9:38 AM, Staff #31 was asked what sort of PPE she was required to wear to sort dirty linens, and she said, gowns and gloves. She was asked if she got trained in the use of Personal protective equipment (PPE) for sorting and she said yes. She was asked if she was taught that protective gowns should be worn for sorting and she said she was taught to wear gloves and mask but not gowns. The surveyor requested to speak to a supervisor.On 9/12/25 at 9:43 AM Staff #27, the laundry supervisor / Accounts manager came in and was asked what sort of PPE's the staff should be wearing for sorting dirty linens, and she said gowns, gloves and masks. She was made aware that her staff were sorting without appropriate PPE's. She said they were trained to use PPEs. She was also made aware of the personal items found on the clean laundry folding tables and she said they belong to a new staff member who just started that has no locker. She was made aware that it was a concern and she said she would do more training.On 9/12/25 at 10:02 AM, the Director of Nursing was made aware of the concerns, she said she will address them.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations and interview with facility staff, it was determined that the facility failed to maintain an effective pest control program. This was observed during the recertification/complaint survey.The findings include:During the survey several observations were made of gnats in the building. On the first day of the survey on 9/8/25 at 7:35 AM, surveyors were placed in the facility's conference room with multiple flying gnats observed in the room. On 9/8/25 at 9:10 AM during initial rounds, the surveyor observed a brown insect and gnat flying around the resident in Room125. The resident tried to swat them and missed. S/he stated flies are a problem.Throughout the survey conducted from 9/8/25 through 9/16/25, there were observations made each day of gnats in the conference room. An interview was conducted with the Maintenance Director on 9/10/25 at 8:57 AM. During the interview he stated the facility had an insect/pest maintenance program by a company called Allstate who comes weekly. When asked if there had been an issue, he stated we had some mice more so last winter and came up with a plan of correction. We took all the ptac covers off the external units of the building and put hardware cloth on top to try to keep the mice out. He also stated, we have some gnats that are seasonal in the summertime. The surveyor shared the sightings of gnats in room [ROOM NUMBER] and the conference room. The Maintenance Director stated, The vendor, Allstate, does not deal with gnats because they say it is a water and cleanliness issue. If you throw a banana peel in the trash and if it's not taken out right away, there will be gnats. We deployed the plastic apples that get filled with apple cider vinegar to address the gnats.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on a review of medical records and interviews, it was determined that facility staff failed to ensure that two physicians' certificates of incapacity were obtained and that Advance Directives were completed in accordance with the Health Care Decisions Act. This was evident for one resident (Resident #1) out of the four residents reviewed for advance directives during the recertification/complaint survey.The findings included:On 9/08/25 at 1:29 PM, the surveyor reviewed Resident #1's medical records. The review revealed that the resident was admitted to the facility in August 2025 with an altered mental status. The form named physician certification related to medical condition, substitute decision making and treatment limitation was completed on 8/14/25 by one physician, who noted that the resident was unable to make decisions due to a state of confusion. However, a second physician's signature was missing.During an interview with Staff #5 (Social Worker) on 9/09/25 at 9:14 AM, she explained the process for physicians' certification regarding residents' decision-making capacity. She confirmed that two signed certifications are required when residents are incapable and that the forms should be completed within a week. She also noted that the facility's staff should monitor the status of these certifications. The surveyor reviewed Resident #1's certification with Staff #6, who confirmed that only one form had been completed.On 9/09/25 at 10:58 AM, Staff #6 stated that the facility had scheduled the second certification, and she verified that this action was arranged after the surveyor's intervention.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility records and interview with staff, it was determined the facility staff failed to: 1) immediately report an allegation of suspected resident abuse and 2) timely report allegations of abuse to the State Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #42) of 35 residents reviewed for intakes during the facility's recertification/complaint survey.The findings include:The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, serious bodily injury, and misappropriation of resident property are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report).A facility reported incident involving Resident #42 was reviewed on 9/15/25 at 6:00 AM. The facility report indicated that facility staff, Guest Services Director (GSD) became aware of the allegation of verbal abuse on 12/11/24 at 8:59 AM. Further review of the facility's initial report revealed the Nursing Home Administrator (NHA) was not notified by the GSD about the allegation until 12/13/24 at 10:00 AM. The facility reported the allegation to the OHCQ on 12/13/24 at 11:50 AM and began an investigation, however this was 2 days after the GSD was made aware of the concerns. The GSD failed to immediately report the allegations to the NHA.On 9/16/25 at 8:28 AM in an interview with the NHA when asked what the expectation would be for any staff member who was made aware of an allegation of abuse, he stated it would be for the staff to report the allegation to their supervisor immediately. Additionally, he stated that the supervisor would then immediately report it to the Director of Nursing or NHA who would start an investigation. During a dual observation with the NHA, the surveyor shared the concern that the initial self-report from the facility documented that the GSD became aware of the allegation on 12/11/24 at 8:59 AM and did not notify the NHA until 12/13/24 10:00 AM. Furthermore, the facility did not submit their initial report until 12/13/24 at 10:00 AM, 2 days after the GSD was made aware of the concerns. The NHA acknowledged and confirmed understanding.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the matrix, medical record review, and staff interview, it was determined that the facility staff failed to ensure Minimum Data Set (MDS) assessments diagnoses were updated. This was evident for 3 (Residents #82, #113, and #13) residents identified with a diagnosis of COVID on the matrix out of 74 resident records reviewed during the recertification/complaint survey process. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Active diagnoses documented on the MDS assessment should correlate with an accurate picture of the resident's current health status.The Facility Matrix is a tool used for assessing the care needs of residents and contains the active diagnoses pulled from the MDS. It also identifies care categories used to determine the appropriate level of care and resources required for each resident. The matrix is completed by the facility and must reflect all residents on the day of the survey. During the infection control facility task investigation, it was noted that 3 Residents, #82, #113, and #13 had a diagnosis of COVID on the Matrix. On 9/11/2025 at 10:35 AM the Infection Preventionist (Staff #3) stated that there were no resident with COVID in the facility.Upon further review of the MDS assessments for all 3 residents on 9/11/25 at 11:12 AM, the Active Diagnoses tab (section I), additional diagnosis indicated UO7.1 COVID 19.In an interview on 9/12/25 at 12:01 PM, the MDS coordinator (Staff #8) stated that he/she was not aware of the diagnosis of COVID for the 3 residents and she will have to look into it.On 9/12/2025 at 12:54, the MDS Coordinator provided an outline related to the 3 residents with the diagnosis of COVID on the Matrix:Resident #82 was admitted on [DATE] with COVID and diagnosis remained in the Diagnosis tab in the MDS when Matrix was pulled on 9/8/25.Resident #113 tested positive for COVID on 4/3/25, the quarterly MDS was done on 6/1/25 and still had a diagnosis of COVID. The following quarterly MDS initiated on 9/1/25 was to be completed on 9/11/25, but the Matrix for the survey entry on 9/8/25 was pulled prior to completion of the 9/1/25 MDS, which had the COVID diagnosis.Resident #13 tested positive for COVID on 4/10/25 and diagnosis remained in the diagnosis tab in the MDS. The Medicare 5 day assessment was done 4/17/25 with the diagnosis of COVID. The quarterly MDS done on 4/18/25 had a diagnosis of COVID which was resolved on 4/23/25. A significant change MDS that was done on 6/16/25 had a diagnosis of COVID and the Matrix pulled on 9/8/25 indicated that resident had a diagnosis of COVID because it was not removed from MDS diagnosis tab.On 9/12/25 at 1:30 PM, the Nursing Home Administrator and DON were made aware that the matrix was wrong and the MDS assessments for the 3 residents were not accurate. They both agreed that this was a concern, and it will be corrected.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview with family, a review of resident medical records, and interviews with facility staff, it was determined that the facility failed to hold care plan meetings at least quarterly. This was evident for 2 (Resident #13, # 2) out of 4 residents reviewed for care plans during the facility's recertification/complaint survey.The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). 1) On 9/8/25 at 12:44 PM, Resident #13's responsible party (RP) was interviewed. During the interview, the RP indicated that s/he had recently received an invitation to a care plan meeting on 9/17/25. However, s/he stated prior to this invitation, s/he had not been invited to or attended a care plan meeting. On 9/9/25 at 2:18 PM review of Resident #13's medical record revealed the resident was admitted on [DATE]. The review failed to reveal evidence that a care plan meeting was held. On 9/9/25 at 2:24 PM in an interview with the Social Worker (SW #5) when asked about care plan meetings she stated, they were held quarterly, every 3 months. During the interview she stated residents' RPs were notified through email or snail mail or if the resident was here in the building, the notification would get hand delivered to them. Additionally, she stated that she created an attendance sheet for the meetings and that they along with the invitations were kept in the social work office. Furthermore, she stated that she documented her interactions with residents and family members. The surveyor requested any and all documentation related to any care plan meetings for Resident #13 such as attendance sheets, invitations, social services notes, et cetera. On 9/10/25 at 9:29AM in a follow up interview with SW #5, she provided the survey team with two documents: an attendance sheet from a 3/28/25 care plan meeting and an invitation for an upcoming care plan meeting scheduled for 9/17/25. When asked if there was documentation/evidence of additional care plan meetings for Resident #13 she stated, No, the only thing I can think is it might have been missed or overlooked. 2) On 09/08/2025 at 1:01 PM during the initial rounding on the units, Resident #2 was asked if s/he was invited to attend a care plan meeting or have attended one. The resident stated that s/he has been in the facility for 7 months but has not had one and was never invited. On 09/09/2025 at 12:40 PM review of the social works (SW) progress notes revealed that the resident had a care plan meeting on 6/26/25. Care Plan meetings are held quarterly, and this resident was admitted on [DATE] so he/she should have had a care plan meeting in May of 2025. Further review did not show that the resident was given advance notice for the care plan meeting. In an interview with the social worker (SW)Staff #5 on 9/9/25 at 1:07 PM, she was asked about the (continued on next page)

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Complete Care at Heritage LLC	7232 German Hill Road Dundalk, MD 21222

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care planning meeting and made aware that Resident #2 was admitted in February 2025 but did not have a care plan meeting until June 2025 which was 4 months later. She confirmed that the residents' care planning meeting was held late because she was the only social worker at the time. She was asked how often the care plan meetings are held and she said that for long term care (LTC) residents, care plan meetings are held quarterly, and families are notified vis email. For residents who are oriented, care plan meeting notifications are hand delivered to them via a letter. She was asked to provide proof that Resident #2 was notified. She stated that she will check On 9/9/25 at 1:40 PM the SW came back to report that she did not have documentation to show that a care plan invite to the June care plan meeting was provided to the resident. She was made aware that it was a concern. On 9/11/25 at 9:42 AM the Director of nursing was made aware of the concerns

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents, review of medical records, and interviews with facility staff, it was determined that facility nursing staff failed to follow professional standards of nursing practice when documenting medications given to residents. This was evident for 1 (Resident #102) out of 2 residents reviewed for timely medication administration during the recertification/complaint survey.The findings include:It is the standard of nursing practice to document administered medications immediately after administration. Failure to do so can result in an inaccurate medical record where it cannot be determined when a medication was given and therefore has the potential to result in medication errors (such as a resident receiving a dose twice or two doses of a medication being given too close in time).On 9/8/2025 at 9:42 AM in an interview with Resident #102 s/he stated that the facility staff waited until his/her pain medications ran out or almost ran out before reordering them and so s/he received the medication late because they had to wait for it to come. On 9/14/2025 at 5:35 PM review of the MAAR [Medication Administration Audit Report] for August and September (up to September 13th) 2025 revealed an order for OxyContin Oral Tablet 20 mg [milligram]. Give 1 tablet by mouth two times a day for back and shoulder pain. On the MAAR, the ordered/scheduled time for administration of the medication was 9:00 AM; however, the following dates/times were when the medication was documented as being administered:08/01/2025 2:06 PM08/02/2025 10:49 AM08/12/2025 11:21 AM08/14/2025 10:11 AM08/26/2025 10:11 AM8/28/2025 10:32 AM09/05/2025 1:12 PM09/08/2025 10:17 AM09/09/2025 11:38 [NAME] the MAAR, the ordered/scheduled time for administration of the medication was 9:00 PM; however, the following dates/times were when the medication was documented as being administered:08/03/2025 10:59 PM08/09/2025 10:15 PM08/13/2025 10:08 PM08/17/2025 10:10 PM08/27/2025 10:38 PM08/31/2025 10:47 PM09/05/2025 10:37 PM09/06/2025 10:12 PM09/07/2025 10:25 PM09/09/2025 10:09 PM09/10/2025 10:28 PM09/13/2025 10:24 PMReview of these MAARs demonstrated a pattern of multiple staff documenting the pain medication late. This practice occurred on 18 out of 44 days (40% of the days) under review and involved a significant pain medication.On 9/14/2025 at 6:08 PM Resident #102's care plan was reviewed and revealed the resident had a care plan for chronic back/shoulder pain. The following interventions were documented to address the chronic pain: Administer my pain medication(s) per order and notify MD if goal is not met with regime. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.On 9/15/25 at 8:09 AM in an interview with the Director of Nursing (DON) when asked about staff reordering medications, she stated the normal process was to reorder the medication when it gets to the last column [on the blister pack]. During the interview she stated, Do they [facility staff] consistently do that, no. Sometimes pharmacy sends a backup card [of the medication], but if not, they are supposed to reorder when it is in the last column. When asked what the standard of practice was for documenting medications, the DON stated immediately after administering. The surveyor shared a few examples of medications being documented hours after the scheduled time and shared this as a concern. The DON verbalized and acknowledged understanding. The surveyor interviewed Registered Nurse (RN #22) on 9/15/25 at 10:43 AM, who was identified as one of the staff documenting medications late. When asked what the standard of practice was for administering medications he stated 1 hour before and 1 hour after the medication was scheduled. During the interview, he stated, So if it is ordered at 9:00 AM, we can start giving it at 9:00 AM and up to 11:00 AM. When asked what the standard of practice was for documenting medications he stated, As I pull each medication, I click sign and then after administering all the resident's medications, I click save which documents that I administered the medications. During a dual observation, the surveyor showed RN #22 several of the above times where the medication was documented as being administered late. RN #22 stated, So I gave it on time, but didn't document on time. The surveyor shared this was a concern and RN #22 acknowledged understanding of the concern.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents, review of medical records, and interviews with facility staff, it was determined the facility staff failed to provide care and services to maintain or improve a resident's ability to carry out Activities of Daily Living (ADLs). This was evident for 1 (Resident #6) of 2 residents reviewed for rehabilitative or restorative services during the facility's recertification/complaint survey.The findings include:ADLs are the basic, essential self-care tasks individuals perform to maintain their daily lives such as hygiene, eating, mobility, and toileting.On 9/8/25 at 8:32 AM in an interview with Resident #6 s/he stated s/he had requested an exercise band several times and was not provided with one. When asked who s/he made the request to s/he stated some aides and nurses, both of whom said Rehab [rehabilitation department: physical therapy (PT), occupational therapy (OT), and speech therapy] would have to make that determination. S/he stated a nursing staff member coordinated a phone call to the Rehab department and Resident #6 requested an exercise band from a female staff member who stated s/he was not able to have one. Resident #6 stated another instance s/he specifically requested an exercise band from Rehab was when a male Rehab staff member came to provide services to his/her roommate and s/he requested one from him. He told Resident #6 he would ask. He left, came back later, and said he was unable to provide one. Resident #6 stated s/he was requesting an exercise band because s/he wanted to exercise and strengthen his/her arms to be able to, as an example, move him/herself in bed because s/he cannot move his/her legs. Furthermore, s/he stated s/he had never been in his/her wheelchair since his/her admission and when s/he had asked, nursing said it was up to Rehab. Resident #6 stated they would call Rehab and Rehab would say s/he could not get up to his/her wheelchair because of his/her pressure ulcers.On 9/9/25 at 11:17 AM in an interview with the Director of Rehab (DOR #7) when asked if Resident #6 was on caseload she stated s/he was initially evaluated on admission and then screened quarterly. When asked if the resident got up to his/her wheelchair or received services, the DOR #7 stated, The Wound Team communicated to Rehab that the resident was not able to get into his/her wheelchair due to his/her sacral wounds being down to the bone and could not come down for Rehab. When asked if she had documentation to support this, she stated she would have to look into it. On 9/9/25 at 11:30 AM in an interview with the DOR #7, the surveyor requested a copy of Resident #6's initial evaluation and all screenings. In addition, a second request was made of documentation of when the Wound Team had communicated to Rehab that the resident could not get into his/her wheelchair. On 9/9/25 at 11:31 AM review of Resident #6's medical record revealed the resident was admitted on [DATE] with diagnoses including but not limited to paraplegia and acquired absence of right leg above the knee. Further review of the medical record failed to reveal documentation from the Wound Team that noted the resident was unable to get out of bed and into his/her wheelchair for any period of time. Additionally, the review revealed a nursing assessment/progress note dated 9/12/24: Bed Rail evaluation completed. Bed Rail(s) in use. - Results: Independently able to turn side to side, not independent in moving up and down in the bed, not able to independently to pull self from laying to sitting position, not able to balance self while transferring to and from bed, not able to independently support self, unable to independently enter/exit bed safely, unable to independently transfer safely to and from bed. - Outcomes: rail served as an enabler with turning side to side/holding self to one side (for comfort, ADL/continence, pressure redistribution, etc.), with assistance rail served as an enabler with moving up and down in bed, with assistance rail served as an enabler with pulling self from laying to sitting position, with assistance rail served as an enabler with improving balance. - Final determination was that rails will be implemented. - Type of rail, bar or pole: Rail: left upper and right upper. Finally, the review of Resident #6's medical records revealed a care plan for:Focus: The resident has limited physical mobility related to disease process and weakness.Goal: The resident (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date.Interventions: - Invite the resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility. - Provide supportive care, assistance with mobility as needed. - Document assistance as needed. - PT [physical therapy], OT [occupational therapy] referrals as ordered, PRN.On 9/9/25 at 12:03 PM in an interview with the DOR #7, she provided the surveyor with two documents: a Therapy Screen Form dated 9/12/24 and a SLP (speech language pathology) Evaluation and Plan of Treatment dated 10/10/24 -11/5/24. The surveyor stated Resident #6 was originally admitted [DATE] and that according to this document provided, s/he was screened and not evaluated on his/her initial admission. When asked what was more comprehensive a screening or an evaluation, DOR #7 stated, An evaluation would be more comprehensive, but it would be case to case and as needed. Initially if there is a concern, we get a nursing referral and I did not receive one, so we just did a screen. When asked if a new admission who was paraplegic but still had upper extremity movement, would benefit from a Rehab evaluation and/or any rehab services, the DOR #7 stated, I think that would have to be case by case. When asked if a resident requested equipment or services, how Rehab would respond, the DOR #7 stated, When I get a nursing referral, we screen and evaluate as appropriate. When asked how referrals were made, the DOR #7 stated, Nursing or any other department can make a referral. During the interview when asked, if a resident requested equipment or services would that trigger a referral, the DOR #7 stated, I did not have a referral for this resident [#6] and s/he is someone who has been dependent since his/her admission. When asked if there was additional quarterly screening documentation for Resident #6 (since in the previous interview DOR #7 stated Resident #6 was screened quarterly), the DOR #7 stated, Those were dates he was due to be screened for, but I said I wanted to check my records to confirm and those two (the two documents she provided from 9/12/24 and 10/10/24) were the only ones I could find. The other dates I provided were times s/he could have been screened. When asked why s/he was not screened quarterly as she had originally stated, the DOR #7 stated, There was no referral provided. When I get a nursing referral, we screen and evaluate as appropriate. During the interview when asked for documentation that the Wound Team communicated to Rehab that Resident #6 could not get up to his/her wheelchair or come down for rehab, the DOR #7 stated, No, I do not have any documentation that the Wound provider [Wound Nurse Practitioner (WNP # 24)] communicated that to the Rehab department. On 9/10/25 at 12:38 PM review of the 9/12/24 Therapy Screen Form revealed the following:Reason for Screen: New/ReadmitScreening Indicator: - There was not one indicator documented as yes or no. - Some of the indicators included: risk for fall (gait/balance/positioning), wound (stage 3, 4, multiple 2), decreased ROM [range of motion]/contracture, decline in ambulation, decline in bed mobility and/or transfers, decline in ADLs (dressing, grooming, hygiene/WC [wheelchair] mobility/toileting), poor bed/WC positioning/restraints, decreased cognition, appropriate for exercise program, was resident on PT/OT before?, is resident appropriate referral to speech therapy? - In the comments section it stated, Pt [patient] admitted from hospital without significant change in status and therefore no services warranted at this time.Recommendation: No Therapy IndicatedOn 9/10/2025 at 12:44 PM in an interview with the Nursing Home Administrator (NHA), the surveyor shared concerns about Resident #6 requesting an exercise band to help keep his/her upper body strong and him/her not being referred to Rehab, screened or evaluated by Rehab, nor given an exercise band. The surveyor also shared concerns that the Resident #6 stated s/he had not been taken out of his/her bed and put in his/her wheelchair once since his/her admission and that when s/he asked staff they told him/her Rehab said s/he could not get out of bed due to the wounds on his/her bottom. The NHA stated we will get him/her a Rehab evaluation. On 9/10/2025 at 12:58 PM review of all documentation from Resident #6's most recent hospitalization (discharged to hospital on 8/28/25 and readmitted to facility on 9/1/25) revealed a Physical Therapy Adult Evaluation. Further review of the evaluation revealed in the Assessment Summary section, Pt would benefit from PT to maximize BUE [bilaterial (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper extremity] strength and progress sitting tolerance as sacral wound healing allows. Recommend: home PT.On 9/10/25 at 2:35PM in an interview with the DOR #7, she provided documentation from WNP #24. Review of WNP #24's progress notes revealed the following:1/15/25- Continue to use Roho cushion when OOB [out of bed] in w/c [wheelchair]. - Avoid sitting up for extended periods of time. Patient education provided.4/8/25- Continue to use Roho cushion when OOB [out of bed] in w/c [wheelchair]. - Avoid sitting up for extended periods of time. Patient education provided.- Wounds are healing nicely without active local signs of wound infection at time of visit. 5/7/25- Continue to use Roho cushion when OOB [out of bed] in w/c [wheelchair]. - Avoid sitting up for extended periods of time. Patient education provided.- Preventative measures: pressure sitting upright in bed exceeding greater than 1-2 hours at a time.The review of WNP #24's progress notes failed to reveal documentation recommending Resident #6 to not get out of bed at all and/or documentation recommending the resident to not get up to his/her wheelchair. On 9/11/25 at 8:23 AM in an interview with the Director of Nursing (DON) when asked which residents are evaluated by Rehab she stated, when a resident was admitted or readmitted , we discuss them the next morning in our clinical meeting and there is a batch order put in for PT to evaluate and treat. During the interview she stated, We just write the initial order for PT and then PT evaluates and makes the decision if they would benefit from therapy. When asked the process if a resident requested equipment such as an exercise band, the DON stated, If a resident requested adaptive equipment, we would let therapy know and therapy takes over. Anything the resident asked us for, we would let therapy and the attending know, but we usually just let [DOR #7's name] know that they are requesting more therapy or equipment and she would follow up on it. We discuss everything in our clinical meeting and go through everything in their [hospital] discharge paperwork. The surveyor requested any policies and procedures related to rehab services, adaptive equipment, et cetera and all 9/1/25 hospital discharge paperwork. On 9/11/25 at 10:17 AM in an interview with the DON she stated we do not have a policy or procedure related to the referral process, but when any resident is admitted or readmitted , a PT order is placed, it is a batch order, for PT to evaluate and treat. During the interview she stated, We also have this form that we fill out when a resident shares a concern or nursing has a concern. The DON stated this was the best copy (the title was cut off) and provided a copy to the surveyor. She verified and confirmed that this was the Referral Form that the facility uses. When asked if one of these forms was completed for Resident #6, she stated no, but she did see the PT note from Resident #6's last readmission recommending PT and that she just spoke with DOR #7 and Resident #6 would be evaluated now. The surveyor requested documentation of a PT order and/or Rehab notes from when Resident #6 returned from the hospital [on 9/1/25]. On 9/8/2025 at 9:00 AM in an interview with Registered Nurse (RN #2) when asked how long he had worked at the facility he stated a little over a year. During the interview when asked if he personally had ever assisted Resident #6 to his/her wheelchair he stated no. Additionally, when asked if he had ever seen Resident #6 in his/her wheelchair in the time he had worked at the facility, RN #2 stated, No, I cannot remember him/her ever in his wheelchair. On 9/11/25 at 11:35 AM in an interview with RN #12 when asked how long she had worked at the facility, she stated, Over a year I have been coming here. During the interview when asked if she personally had ever assisted Resident #6 to his/her wheelchair she stated no. Additionally, when asked if she had ever seen Resident #6 in his/her wheelchair in the time she had worked at the facility, RN #12 stated, No, I have not ever seen him/her sitting in his/her wheelchair. On 9/11/25 at 11:40 AM in an interview with Resident #6 s/he stated, No, I have not got up to the wheelchair since we last spoke on Monday [9/8/25]. On 9/11/25 at 11:43 AM review of the facility's policy for Assistive Devices revealed, Purpose- To ensure resident/patients in need of an assistive device is provided with proper equipment to enhance functional skills and abilities, improve communication and resident/patient participation in social and recreational and community activities. Further review revealed, Policy- Assistive devices will be provided to resident/patients to increase activities of daily living and quality of life. Additionally, the policy stated, Procedure- 1. Staff should (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be knowledgeable regarding type and availability of assistive devices and evaluate resident/patient, noting specific assistive devices needed for resident/patient's abilities and disabilities. On 9/11/25 at 11:54 AM in an interview with the DON she stated she asked the Unit Manager (UM #1) if there was a PT order to evaluate and treat Resident #6 and this was what she provided (and handed 2 orders to the surveyor). Both orders were for PT eval (evaluate) and tx (treat) with one dated 9/1/25 and the other dated 9/11/25. During a dual observation, the DON observed the surveyor pull up Resident #6's medical record on the computer and that the PT order dated 9/1/25 was ordered was today, 9/11/25, after surveyor intervention. When asked prior to surveyor intervention was there an order when Resident #6 came back from the hospital on 9/1/25 for PT to evaluate and treat, she stated no. The surveyor shared this was a concern and the DON acknowledged understanding.On 9/11/25 at 12:10 PM in an interview with the DON and Nursing Home Administrator (NHA) he stated there are different things that will trigger a PT eval. During the interview the NHA stated, Yes, a resident requesting should be enough to trigger a PT eval. He also stated, There was no order placed when the resident returned from the hospital for PT. The surveyor shared the concern that the DON had stated that all admissions/readmissions were ordered a PT order and that all hospital discharge paperwork is reviewed the morning after admission in the clinical meeting. Moreover, Resident #6's hospital discharge paperwork recommended PT. The NHA acknowledged understanding. The surveyor also shared the concern that Resident #6 stated he/she asks to get up to his/her wheelchair and stated s/he had never been able to. The NHA stated, We looked and there was no order saying the resident could not get up to his/her wheelchair. The DON stated that the resident often refused to get out of bed. The surveyor requested documentation to support this. On 9/11/25 at 1:20 PM in an interview with the DON she stated, I did not find a progress note or care plan that the resident [#6] refused to get out of bed.On 9/15/25 at 1:28 PM in an interview with the Wound Nurse (WN #25) when asked if she ever communicated to Rehab that Resident #6 could not get up to his/her wheelchair because of his/her pressure ulcers she stated, No, and I do not know of anyone on the Wound Team that said s/he could not get out of bed at all.

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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 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. 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 (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interviews, it was determined that the facility failed to provide adequate fall risk assessments for residents who experienced frequent falls. This was evident in the cases of 3 residents (Resident #15, #16, and # 94) out of the five reviewed for fall risks during the recertification/complaint survey. The findings included: 1) During an interview with Resident #15 on 9/08/25, at 8:41 AM, the resident reported a fall that led to a hospital transfer a couple of months prior. An observation of the resident's room revealed the bed was high, with no fall mat or other precautions in place. A review of Resident #15's medical record on 9/09/25, at 1 PM, showed the resident was found on the floor beside the bed on 7/22/25, at 9:23 PM. The resident complained of hip pain and was transferred to the hospital for evaluation. Imaging at the hospital revealed a partial dislocation of the left arm and a compression fracture in the spine. The resident was re-admitted to the facility on [DATE]. A further review of the medical record showed a fall assessment was completed on 7/22/25, at 8:58 AM (before the fall occurred), which categorized the resident as low risk with a score of 3. There was no additional assessment completed after the fall. In an interview with the Director of Nursing (DON) on 9/11/25, at 8:03 AM, she stated that fall assessments should be completed upon admission, quarterly, whenever there is a change in physical function, and after a fall. The surveyor and the DON reviewed Resident #15's medical records together, and the DON confirmed that a fall assessment was not completed after the fall incident. 2) In an interview with Resident #16 on 9/08/25, at 8:56 AM, the resident reported having had many falls. On 9/09/25, at 2:24 PM, a review of Resident #16's medical records revealed the most recent incident was an unwitnessed fall on 9/04/25, at approximately 11:45 AM. The review further revealed that no fall assessment was completed after the fall on 9/04/25. During an interview with the Director of Nursing (DON) on 9/11/25, at 11:20 AM, she confirmed that a fall assessment should have been done for Resident #16 immediately after the fall. She stated, fall assessment not completed consistently. The surveyor shared concerns regarding the fall assessments, and the DON validated it. 3) During the Screening phase of the survey on 09/08/25 at 11:28 AM, Resident # 94 stated, I had fallen before at this facility. Resident was observed in room in wheelchair with bed in low position. On 09/08/25 at 11:54 AM, the medical record revealed that resident fell, sat on floor and was assisted back to bed on 7/14/25 at approximately 6:30 PM. Another fall occurred on 7/18/25 at approximately 7:30 PM that resulted in Resident #94 transferred to the hospital with a suspected injury. No falls assessment was documented in the medical record after the falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 09/11/2025 at 8:03 AM, she confirmed that a fall assessment should be done after a fall had occurred. Surveyor requested copies of the fall assessment for Resident #94. On 09/11/2025 at 1:25 PM, DON could not locate any falls assessments that were completed after the date of the falls on 7/14/25 and 7/18/25. DON agreed that this was a concern and that she would educate the staff.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the resident's medical records and interviews with facility staff, it was determined that the facility failed to address a significant weight loss for a resident. This was evident for one (Resident #9) of 2 residents reviewed for nutrition during the recertification/complaint survey.The findings include:During an interview with Resident #9 on 09/08/25 at 11:10 AM, the resident reported a weight loss.A review of Resident #9's medical records on 09/09/25 at 8:32 AM revealed that the resident had experienced significant weight loss multiple times while residing in this facility: On 03/12/25, weight was 127.2 lbs. (via mechanical lift). On 03/27/25, weight was 111.4 lbs. (via mechanical lift). This was a loss of 15.8 lbs. (12.4%) within 15 days. The resident remained in the facility and was not transferred to a hospital or for a procedure. On 06/06/25, weight was documented as 105.2 lbs. (via wheelchair). On 06/11/25, weight was 100 lbs. (via lift). This was a loss of 5.2 lbs. (4.9%) within 5 days. On 06/18/25, weight was 96 lbs. (via lift). This was a loss of 4 lbs. (4%) within 7 days.Further review of Resident #9's medical records revealed that nutrition assessments were completed on 12/27/24, 04/04/25, 05/03/25, 06/09/25, and 09/08/25 by a dietitian (Staff #6). Staff #6 also wrote nutrition notes on 02/01/25 and 07/25/25. However, there was no documentation to address Resident #9's significant weight loss.In an interview with Staff #6 on 09/09/25 at 10:12 AM, she stated that nutrition assessments were required upon admission, every 90 days, and when a resident's weight loss was identified. She explained that the facility held weekly weight loss meetings with the clinical team to discuss residents' plans of care. The surveyor asked about Resident #9's significant weight loss and whether there was any documentation for it.On 09/09/25 at 11:08 AM, Staff #6 provided a copy of a nutrition assessment dated [DATE]. She said, The weight loss happened in the period, so it was assessed on 06/09/25. The surveyor asked if the weight loss for Resident #9 from 06/06/25 to 06/11/25 was significant. Staff #6 confirmed that it was. The surveyor then asked what interventions were implemented after the facility identified the significant weight loss. Staff #6 verified that there was no documentation to support any interventions.During an interview with the Director of Nursing (DON) on 09/11/25 at 2:02 PM, the surveyor reviewed Resident #9's medical records related to weight loss. The DON validated that there was no documentation presented for an assessment, notification to a family member and provider, a revised care plan, and/or additional interventions to address the resident's significant weight loss.

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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.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to properly label and store drugs and biologicals. This was evident in 2 of 4 medication carts observed during the recertification/complaint survey. The findings include: According to the CDC and American Diabetes Association (ADA) recommend refrigerating unopened insulin at 36-46 F (2-8 C) until the expiration date, while opened insulin vials can be kept at room temperature (below 86 F or 30 C) for about 28 days, depending on the manufacturer's guidelines. The standard of practice requires that, when opened, a vial or pen of insulin would be labeled with both an opened date and or a discard after date which is 28 days later.On [DATE] at 10:55 AM, during an observation of the 2nd floor East Hall medication Cart accompanied by Staff #35 (Agency Nurse) revealed the following: 1) A unsealed Lantus 100 unit/ml vial labeled with Resident #192's name and not labeled with the date it was opened.2) An opened box of Ipratropium/Solution Albuterol (a prescription medication used in a nebulizer to open the airways and make breathing easier) labeled with Resident # 95's name and not labeled with the date it was opened.3) An unsealed Insulin Lispro pen 100 U/ml labeled with Resident #192's name and not labeled with the date it was opened.4) An unsealed Insulin Lispro pen labeled with Resident #193's name and not labeled with the date it was opened.5) An opened box of Albuterol 2.5mg/3ml (0.083%) Solution (a prescription medication used in a nebulizer used to treat wheezing and shortness of breath) labeled with Resident #138's name and not labeled with the date it was opened.On [DATE] at 11:05 AM, during an interview with Staff #35 (Agency nurse), stated the unsealed Insulins should have a date on them and the opened boxes of solutions for nebulizer treatments should have a date on the foil pack and the box when opened. At this time Staff #35 acknowledged Surveyors' findings during observation of 2nd Floor East Hall medication cart.On [DATE] at 11:15 AM, during an observation of 2nd floor North Hall medication cart accompanied by Staff #30, revealed the following:1) An unsealed Insulin Lispro Pen 100 U/ml labeled with Resident #192's name and not labeled with the date it was opened.2) A 100 tablet bottle of Over-the-Counter (OTC) medication of Oyster Shell Calcium 250mg + Vit. D that had an expiration date of 07/2025.3) A 300 tablet bottle of Over-the-Counter (OTC) medication of Calcium 600mg +D3 that had an expiration date of 04/2025On [DATE] at 11:20 AM, during an interview with Staff #30, stated the Insulin pen should have been dated, and the two bottles of expired over-the-counter medications should have been removed from the medication cart. At this time Staff #30 acknowledged Surveyors' findings during observation of 2nd Floor North Hall medication cartXXX[DATE] at 11:25 AM, during an interview with Staff #28 (Unit Manager) stated, any insulin kept in the medication cart must be dated and refrigerated until opened. Over the counter (OTC) medications that have expired should be removed from the cart. All nebulizer medications must be dated once they are opened.On [DATE] at 11:35 AM concerns were shared with the Director of Nursing.

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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. Based on clinical record review, review of facility report incidents, and staff interview it was determined that the facility staff failed to ensure residents' clinical records were complete and accurate. This was evident for 3 (Residents #4, #137, #190) residents out of the 74 in the survey sample of the recertification/complaint survey. The findings include: 1) During a recertification/ complaint survey conducted from 09/08/2025 through 09/16/2025 a review of facility complaint MD# 333479 was conducted. Review of the intake information revealed that the Baltimore County Fire Department was requested by the facility for a potential overdose of Resident #190 on 09/25/24. The Emergency Medical Response team complained that the facility did not allow them to review the residents' medication administration sheets. On 9/11/25 at 10:01 AM a review of the Resident #190's medical record noted that Oxycodone HCL Oral Tablet 10 MG (Oxycodone HCl) was ordered on 9/13/24, discontinued on 9/17/24 and reordered on 9/17/24 and placed on hold on 9/25/24 to 9/26/24. The narcotic count sheet revealed that Oxycodone 10 mg 1 tab was signed out on 9/16/24 at 2 pm and 8 pm; 9/17/24 at 11 pm; 9/18/24 at 11 pm; 9/23/24 at 2 pm and 8:20 pm; 9/24/24 at 8 pm. However, a review of the resident's Medication Administration Record (MAR) on 9/11/25 at 10:30 AM had missing documentation (left blank) of the above dates and times. An interview was conducted on 09/15/2025 at 11:02 AM with an LPN (Staff # 30) when asked about documentation of medications to include narcotics, Staff #30 stated that documentation of medications should be completed when the medication was administered to the Resident. Staff #30 also stated that when a narcotic is removed from the narcotic pack, it is documented in the narcotic sign out binder and documented on the MAR when the medication is taken by the resident. On 09/15/2025 at 3:06 PM an interview was conducted with the DON who agreed that medications must be documented on the MAR when administered. 2) A review of Resident #4's clinical record on 9/15/25 revealed that the resident's physician ordered nursing to administer insulin Lispro 100 unit/ml solution via a pen injector and to inject an amount based on a sliding scale according to blood sugar levels. The Medication Administration Record (MAR) for September was reviewed for compliance with this order. The amount of insulin that was administered on any day and time that the amount of blood sugar was high enough to warrant administration of insulin was not recorded. Recording the amount is important as it helps to ensure the resident is administered the proper amount and allows the physician to be aware of any trends in the resident's treatment. The Director of Nursing (DON) was interviewed on 09/16/2025 at 11:25 AM. This surveyor showed her the September MAR. This surveyor asked how much insulin did the nurse administer and she did not initially answer. The surveyor asked again but this time the surveyor showed her the equal sign and asked her what the equal sign means. She replied I don't know. I'll find out. The DON and the unit manager for the first-floor nursing unit were interviewed on 09/16/2025 at 1:05 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM. They said that the nurse who put the order into the system put the order in wrong. The section of the computer screen where the medication dosage was input, the nurse created it so that an = sign was shown not the actual dosage administered. They demonstrated how staff would input the blood sugar level measured and how it comes up as = instead of the number of cc's administered. They were informed it would be a medical records deficiency, and they acknowledged understanding the finding. 3) This surveyor reviewed on 9/9/25 the facility reported incident (333487) for resident #137 revealed the resident was found on 1/17/25 at 12:00 PM to be unresponsive by the pain management physician. The physician notified the nurse who ran back to the room with the physician. They made several attempts to waken the resident. The resident did awaken but when the nurse attempted to get vital signs the resident became combative. The resident then became unresponsive again. The facility physician was notified and reported to the resident's bedside. Narcan (medication to treat opioid overdose) was ordered by the physician and administered as ordered with the physician present. The nurse continued to monitor the resident throughout the shift. A review on 9/9/25 of the resident's clinical record revealed that the January Medication Administration Record (MAR) did not show an order for Narcan had been transcribed or any indication that the medication was administered. The Staff Educator (Staff #3) was interviewed on 9/9/25 at 11:00 AM. This surveyor discussed the Narcan have been administered but not on the MAR. She acknowledged the finding and said she would let the Director of Nursing (DON) know so she could follow up. The DON was interviewed on 9/11/25 at 1:20 AM. She said she could not find the order for the Narcan or a record on the MAR of it being administered. The surveyor informed her this would be a concern because of the importance of record keeping. If the resident was ever sent to the hospital, they would need to know what medications the resident received as well as what medications have been ordered for the resident. The failure to have this information recorded also denied the pharmacist the ability to review all of the medications the resident received. The surveyor interviewed the first-floor unit manager on 9/12/25 at 1:30 PM. The surveyor asked what is sent with a resident when a resident is sent to the hospital. She replied, when a resident goes out 911 to the hospital we send the bed hold policy, a medication list, the reason for sending the resident, and any special instructions.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and staff interview, it was determined that the facility failed to offer pneumococcal vaccine as appropriate for residents. This was evident for 1(Resident #2) of 5 residents reviewed for immunizations during the recertification/complaint survey.The findings include:On 9/12/15 at 1:00 PM a review of Resident #2's immunization records failed to show that a pneumococcal vaccine which protects against Pneumonia, a lung infection, was offered to the resident or that resident refused and was educated.On 9/12/25 at 2:15PM Staff #3 the Infection Preventionist (IP) was asked if the facility offers the Pneumococcal vaccine to their residents. She stated that they do offer it on admission. She was asked if Residents #2 was offered the vaccine and she said she will check.On 9/15/25 at 10:44 AM Staff #3 provided a Pneumococcal vaccine Informed consent form dated 9/15/25 and said that the vaccine was not offered initially to the resident on admission and that she just spoke with Resident #2 who consented to get the pneumonia vaccine. She was made aware that it was a concern.AT 9/15/25 at 11:44AM, the Director of Nursing was made aware of the concerns.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interviews, it was determined that the facility failed to offer COVID-19 immunization as required or appropriate for residents. This was evident for 2 (Residents #1 and #2) of 5 residents reviewed for immunizations during the recertification/complaint surveyThe findings include:A Covid -19 vaccine is a vaccine intended to provide acquired immunity against severe acute respiratory syndrome Coronavirus 2.On 9/12/15 at 1:00 PM review of Resident #1 and #2's immunization records failed to show that a Covid 19 vaccine was offered to the residents or that both refused and were educated. Further review did not produce the missing documents.On 9/12/25 at 2:15PM Staff #3 the Infection Preventionist (IP) was asked if the facility offered Covid -19 immunizations to their residents and she said they do and explained that they offer it on admission. She was asked if both residents were offered the Covid-19 Immunization on admission and she said she would check and get back to the surveyor.On 9/15/25 at 10:44 AM Staff #3 provided two Covid-19 vaccine consent forms dated 9/15/25 for both residents showing that Resident #2 consented to have the vaccine administered while Resident #1 refused and was educated. She stated that it was not offered initially on admission to both residents, so she went ahead and just offered it to them. She was made aware that it was a concern.On 9/15/25 at 11:44AM, the Director of nursing was made aware of the concerns.

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

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of employee files and staff interview it was determined that the facility failed to demonstrate the implementation of a process to track nurse aide participation in required training's to ensure all nurses' aides received 12 hours of training that included abuse prevention and Dementia management, annually and addressed areas of weakness as determined in nurse aides' performance reviews. This was evident for 2 (GNA # 16 and #17) of 5 employees' files reviewed during this recertification/complaint survey.The findings included:On 9/11/25 at 9:40 AM, a surveyor reviewed five randomly selected Geriatric Nursing Assistant (GNA) employee files, which revealed the following: GNA #16: Hired in July 2024, this employee's training records show that the second page of their abuse and neglect prevention training was not completed on 7/17/24. GNA #17: Hired in December 2022, this employee's training records contained no evidence that they received the required training in 2023.During an interview with Staff #3 (an educator) and the Nursing Home Administrator (NHA) on 9/11/25 at 1:18 PM, Staff #3 stated that the facility provides an online training program for staff, which she monitors. However, when the surveyor reviewed GNA #16's and #17's employee files with Staff #3, she confirmed that GNA #16 had not completed the abuse prevention training, and GNA #17 had no records of the required training for 2023.

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

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and interviews with facility staff, it was determined that the facility failed to post all of the required staffing information on a daily basis and was observed during the recertification/complaint survey.The findings include:On 9/08/25, at 7:30 AM, the survey team entered the facility for the annual survey. The team toured the facility and their observations of staffing post revealed that the required staffing information was not posted in a public area.During an interview with the Director of Nursing (DON) on 9/15/25, at 8:15 AM, she stated that the facility has assignments for each unit. However, they do not post the staffing information, including the facility name, date, resident census, and the total number and actual hours worked by nursing staff, in a public area. The surveyor shared this concern, and the DON validated it.