STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215143	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Severna Park LLC	310 Genesis Way Severna Park, MD 21146

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation and interview, it was determined that the facility failed to ensure residents' call bells were accessible to residents. This was found evident for 4 (Residents #15, #16, #17, and #20) out of 4 Residents reviewed for call bells during the complaint survey. The findings include:According to the Centers for Medicare & Medicaid Services (CMS), a call bell-also referred to as a resident call system-is a communication device that allows residents to summon staff assistance when needed.On 10/20/2025 at 11:11 AM, this surveyor observed Resident #15 in his/her room. The Resident was lying in bed, and the call bell was found inside the bedside table drawer, out of the Resident's reach.On 10/20/2025 at 11:21 AM, this surveyor observed Resident #16 in his/her room. The Resident was seated in a wheelchair next to the bed, eating breakfast. The call bell was observed on the opposite side of the bed, out of the Resident's reach.On 10/20/2025 at 11:24 AM, Resident #17's call bell was observed wrapped tightly around the bed rail on the opposite side of the bed. The resident was seated in a wheelchair on the opposite side of the bed, and the call bell was not within the resident's reach.On 10/20/2025 at 11:27 AM, this surveyor interviewed Registered Nurse (RN) #6, who stated that it was her responsibility, as well as the aides' responsibility, to ensure residents have access to their call lights.On 10/20/2025 at 11:31 AM, this surveyor conducted a dual observation with RN #6 in Resident #17's and Resident #16's rooms, where the residents' call lights were not within reach. The RN acknowledged the issue, apologized, and repositioned the call lights so they were accessible to the residents.On 10/20/2025 at 11:52 AM, this surveyor went into Resident #20's room and observed his/her call bell was laying on the floor, underneath his/her roommate's bed. On 10/20/2025 at 11:53 AM, this surveyor interviewed GNA #8. When asked about her process for ensuring residents have access to their call bells, she stated that she typically checks to make sure residents have their call bells but did not specify a consistent schedule for doing so. On 10/20/2025 at approximately 12:00 PM, this surveyor conducted a dual observation with GNA #8 in Resident #20's room. Resident #20's call bell was observed on the floor. GNA #8 retrieved the call bell and handed it to the resident. The concern was discussed with GNA #8, that residents must have access to their call bells to contact healthcare staff. GNA #8 stated that she understood the concern.On 10/21/2025 at 11:17 AM, this surveyor conducted an interview with the Administrator. The Administrator was informed of residents who did not have access to their call bells, as well as the interviews with RN #6 and GNA #8 regarding residents who did not have their call bells accessible. The Administrator stated that a call bell audit would begin that day to check every call bell in each resident room and address the issue.

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	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-reported incident investigation, record review, and interview, it was determined that the facility failed to ensure that a resident remained free of abuse. This was evident for 2 (Resident #6 and #8) of 11 abuse investigations reviewed during the complaint survey. The findings include: 1) The facility's investigation related to facility-reported incident #2641751 was reviewed by the surveyor on 10/24/25 at 10:32 AM. The investigation revealed that the facility substantiated the allegation based on Resident #21's statement, which indicated that agency staff Geriatric Nursing Assistant (GNA) #4 engaged in verbally abusive behavior, including yelling and using inappropriate language, specifically stating, Shut the f*** up if you are able to do it yourself, why don't you? while providing care to Resident #6. During record review on 10/24/25 at 8:00 AM, it was noted that the facility conducted an interview on 10/14/25 with Resident #21's family member (roommate). The family member stated that he/she overheard GNA #4 respond to Resident #6 by saying, I'm not hurting you, just lay there and shut up. The family member stated that the more Resident #6 asked the GNA to stop, the more the GNA yelled. On 10/24/25 at 8:29 AM during an interview with Resident #6, it was revealed that the facility had informed the resident of the outcome of the investigation and assured him/her that safety would be maintained. When asked if the situation had been resolved, Resident #6 stated, GNA #4 is no longer here. I have no concerns about the facility. During an interview with the Director of Nursing (DON) on 10/24/25 at 10:00 AM, she stated that the verbal abuse allegation was substantiated based on the facility's investigation. GNA #4 is no longer permitted to work at Complete Care Severna Park. The DON further stated that the facility reported the incident to the Maryland Board of Nursing. 2) On 10/20/25 at 8:51 AM, a review of Facility- Reported incident #349643 revealed that on 7/3/25, at approximately 9:35 AM, GNA #8 allegedly grabbed tea bags from Resident #8's hands. Based on an interview conducted by the facility with witness, GNA #3, it was stated that while distributing breakfast trays in Unit 2, GNA #3 observed Resident #8 took 3 tea bags from the cart. GNA #2 then took the tea bags from the Resident #8's hands, which GNA #3 described as a tugging back and forth motion. A follow-up interview was conducted by the facility with Resident #8 on 7/3/25 at 10:30 AM, Resident #8 confirmed taking 3 tea bags from the cart and described that GNA #2 grabbed and was pulling my hands multiple times back and forth trying to take the tea bags from me. GNA #2 could have pulled me out of my chair as hard as he/she was pulling. Resident #8 added that hands and arms now feel weaker and tingly since. On 10/20/25 at 11:06 AM, a review of Resident #8's medical records revealed a BIMS (Brief Interview for Mental Status: an assessment used in nursing homes and other long-term care facilities to monitor cognition) score of 15 out of 15 indicating intact cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/20/25 at 12:05 PM, in an interview with Resident #8, he/she confirmed that GNA #2 forcibly took the tea bags from his/ her hands, resulting in increased pain to his/her wrists. On 10/20/25 at 12:15 PM, the Change in Condition Evaluation dated 7/3/25, at 5:53 PM, confirmed that Resident #8 had a pain scale of 9 out of 10. The Numerical Rating Scale (NRS) is a pain assessment tool where patients rate their pain on a scale, typically from 0 to 10, with 0 meaning no pain and 10 meaning the worst pain imaginable. On 10/20/25 at 2:08 PM, during an interview with the Director of Nursing (DON), she confirmed the allegation of abuse was verified by the facility. She stated that GNA #2 was initially placed on administrative leave and subsequently terminated. She stated that the incident was verified based on the statements of Resident #8 and GNA #3. The DON acknowledged that the incident was a concern.

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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-reported incident investigation, record review and staff interviews, it was determined that the facility failed to report to the Office of Health Care Quality (OHCQ) within the required timeframe. This was evident for 2 (Resident #6 and #14) out of 2 residents reviewed for reporting abuse allegations during the complaint survey process. The findings include: 1) On 10/21/25 at 8:40 AM surveyor reviewed the facility-reported incident (FRI) #2620209 for Resident #6 revealed that on 9/16/25 at 3:30PM, Resident #6 sustained an injury of unknown origin (left hip fracture). Further review of the facility's investigation on 10/21/25 at 8:50 AM revealed that the facility submitted the initial report of the incident to the Office of Health Care Quality (OHCQ) on 9/17/25 at 3:17 PM. The final investigation report was not submitted to OHCQ until 9/25/25 at 9:19 PM. The facility is required to submit the initial report within 2 hours of the incident and the final investigation report within five working days. On 10/24/25 at 9:30 AM during an interview with the Director of Nursing (DON) regarding the reporting of incidents involving injuries of unknown origin, she stated that the facility is required to report within 24 hours, and the final investigation is submitted within five working days. On 10/24/25 at 12:30 PM the Administrator and the DON were informed of the above concerns and acknowledged receipt. 2) On 10/22/25 at 11:43 AM, the surveyor reviewed the FRI #2564111 for Resident #14. The review revealed that on 7/15/25 at approximately 1:30 PM, Resident #14 alleged to the Psych Social Worker, and then to Unit Manager (UM) #15 and Social Services Director (SSD) that a male visitor engaged in inappropriate physical contact during a visit on 7/14/25, including touching his/her chest without consent and requesting a kiss. Further review of the facility's investigation revealed that on 7/15/25 at approximately 3:45 PM, UM #15 and the SSD contacted Resident #14's daughter regarding the alleged incident. During the call, they informed the daughter that Resident #14 had reported that he/she did not feel abused and did not want the interaction reported or the police contacted. However, there was no evidence that staff immediately reported the allegation of mistreatment to the Administrator as required. On 7/16/25 at 12:48 PM, UM #15 received an email from Resident #14's daughter referring to the incident as a sexual assault and requesting documentation for Resident #14's records. UM #15 informed the Administrator, and both contacted Resident #14's daughter by phone to discuss the email. During the call, UM #15 stated that Resident #14 did not want the incident involving the male visitor reported or the police contacted. Resident #14's daughter responded that, as her relative's representative, she wanted the incident reported and the police notified. This was when the Administrator became aware of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/20/25 at 1:42 PM, an interview with UM #15 and the SSD confirmed that Resident #14 reported the alleged incident of mistreatment to both of them on 7/15/25; however, the Administrator was not made aware of the alleged incident until Resident #14's daughter emailed the facility on 7/16/25. UM #15 and the SSD further stated that the Administrator was not notified because Resident #14 told them he/she did not feel abused and did not want the incident reported. Review of the facility's policy titled Abuse, Neglect, Exploitation (last reviewed/revised 9/12/24) revealed that the facility is required to report all allegations of abuse, neglect, exploitation, or mistreatment immediately to the Administrator and to appropriate agencies within 24 hours of discovery, and within 2 hours in cases involving abuse or serious bodily injury. On 10/20/25 at 2:43 PM, an interview with the Administrator confirmed that she became aware of the alleged incident involving Resident #14 and the male visitor after UM #15 received an email from Resident #14's daughter on 7/16/25 at 12:50 PM. The Administrator stated that the email referred to the incident as a sexual assault. Subsequent review of the facility's investigative file revealed that the facility submitted the initial report to the OHCQ on 7/16/25 at 2:20 PM. However, Psych Social Worker, UM #15, and SSD became aware of the allegation on 7/15/25 at approximately 1:30 PM, which exceeded the required 24-hour timeframe. At the time of the exit conference, the facility did not provide documentation showing that Resident #14's allegation of mistreatment was reported to the Administrator and OHCQ within the required timeframe.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility-reported incident investigation, record review, and interview, it was determined that the facility failed to thoroughly investigate an allegation of abuse. This was evident for 1 (Resident #8) of 11 abuse investigations reviewed during the complaint survey.The findings include: On 10/20/25 at 8:51 AM, a review of Facility- Reported incident #349643 revealed that on 7/3/25, at approximately 9:35 AM, Geriatric Nurse Assistant (GNA #8) allegedly grabbed tea bags from Resident #8's hands. The facility's interview with GNA #3 revealed that while distributing breakfast trays in Unit 2, GNA #3 observed Resident #8 took three tea bags from the cart. GNA #2 then took the tea bags from Resident #8's hands in what GNA #3 described as a tugging back and forth motion. A follow-up interview was conducted by the facility with Resident #8 on 7/3/25 at 10:30 AM, Resident #8 confirmed taking 3 tea bags from the cart and described that GNA #2 grabbed and was pulling my hands multiple times back and forth trying to take the tea bags from me. GNA#2 could have pulled me out of my chair as hard as he/she was pulling. Resident #8 also reported that hands and arms now feel weaker and tingly since. The facility interviewed other residents assigned to GNA #2, with 7 residents denying any abusive encounter with GNA #2, However, the facility failed to conduct skin assessments for 4 cognitively impaired residents. On 10/20/25 at 11:06 AM, a review of Resident #8's medical records revealed a BIMS (Brief Interview for Mental Status: an assessment used in nursing homes and other long-term care facilities to monitor cognition) score of 15 out of 15 indicating intact cognition. On 10/20/25 at 12:05 PM, in an interview with Resident #8, he/she confirmed that GNA #2 forcibly took the tea bags from his/ her hands, resulting in increased pain to his/her wrists. On 10/20/25 at 12:15 PM, the Change in Condition Evaluation dated 7/3/25, at 5:53 PM, confirmed that Resident #8 had a pain scale of 9 out of 10. The Numerical Rating Scale (NRS) is a pain assessment tool where patients rate their pain on a scale, typically from 0 to 10, with 0 meaning no pain and 10 meaning the worst pain imaginable. On 10/20/25 at 2:08 PM, during an interview with the Director of Nursing (DON), she confirmed that the allegation of abuse was verified by the facility. She stated that GNA #8 was initially placed on administrative leave and subsequently terminated. The DON stated that other like residents (alert and oriented like Resident #8) assigned to GNA #2 were interviewed, however, she confirmed that body checks/assessments were not performed for non-verbal residents. On 10/23/25 at 8:41 AM, the Nursing Home Administrator (NHA) confirmed that part of investigating an abuse allegation involved interviewing other residents assigned to the alleged perpetrator. She also confirmed that body checks were expected for the non-verbal/vulnerable residents. On 10/24/25 at 2:13 PM, the DON was notified of this concern and acknowledged it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that the facility failed to have accurate documentation for a resident. This was found to be evident for 1 (Resident #2) out of 1 Resident reviewed for accurate documentation during the complaint survey. The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.Speech-language pathology services are those services necessary for the diagnosis and treatment of speech, language and cognitive communication disorders which result in communication disabilities. Speech-language pathology includes evaluation and treatment of swallowing.On 10/24/2025 at 08:17 AM, this surveyor conducted a record review of Resident #2's care plan. The care plan included interventions stating, Please ensure the resident is supervised during meals and Resident to eat only with supervision.On 10/24/2025 at 10:05 AM, this surveyor conducted a record review of the Speech-Language Pathologist (SLP) visit dated 05/16/2025. Under the Recommendations section, it stated, Supervision with meals.On 10/24/2025 at 10:31 AM, this surveyor reviewed documentation for the Activities of Daily Living (ADL) sheets for May 2025 and June 2025. The documentation reflected assessments of the level of assistance Resident #2 required for the activity of Eating. According to the document, Independent is defined as resident completes the activity by themselves with no assistance from a helper, and Supervision or touching assistance is defined as helper provides verbal cues and/or touching, steadying, and/or contact guard assistance. Assistance may be provided throughout or intermittently. Review of the ADL documentation showed that on May 1, 2, 3, 20, 22, 23, 24, 25, and June 28, the Resident was documented as Independent for eating.On 10/24/2025 at 12:16 PM, this surveyor interviewed Unit Manager #17 regarding Resident #2's level of care required during eating activities for the months of May and June 2025. She stated that the Resident required supervision during meals. When asked to clarify, she explained that supervision entails having someone present in the area while the Resident is eating. She confirmed that Resident #2 would not be considered Independent because a staff member would need to be present to observe her eating. The surveyor then showed Unit Manager #17 the ADL documentation for May and June 2025, highlighting the dates on which Resident #2 was marked as Independent for the activity of Eating. When asked if she knew of any reason why the Resident was marked as Independent, she could not provide a reason. The surveyor discussed concerns that Resident #2 had a care plan indicating supervision was required during meals, a recommendation from the SLP for supervision with eating, and documentation on several occasions marking the Resident as Independent. Unit Manager #17 reported understanding these concerns.On 10/24/2025 at 2:01 PM, this surveyor interviewed the Administrator regarding Resident #2. The surveyor showed her the ADL documentation for May and June 2025, highlighting the dates on which the Resident was charted as Independent for the activity of Eating, and explained the concern that the Resident's care plan and SLP recommendation indicated supervision was required during meals. The Administrator confirmed that the issue was possibly related to education or knowledge gaps among staff documenting Independent instead of Supervision. She stated that it is likely due to staff not knowing the difference between Independent and Supervision. The Administrator reported that she would address this issue by providing education to staff who had documented the Resident as Independent for the activity of Eating, clarifying the difference between the two levels of assistance.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, it was found that the facility failed to have a functioning call bell system for residents. This was found to be evident for 7 (Resident #18, #19, #20, #22, #23, #24, and #25) out of 7 residents reviewed for call bell function during the complaint survey. The findings include:A call bell system is a communication device that enables residents to summon staff for assistance. The system activates a visual and audible signal to alert staff when a resident requests help. When staff respond and acknowledge the call, the signal is turned off, indicating that the resident's request has been addressed. The system is intended to ensure residents have reliable access to staff for timely care and assistance. TELS (Total Equipment Logging System) is the facility's computerized system used to document, track, and manage maintenance work orders and service requests.On 10/20/2025 at 11:45 AM, this surveyor conducted a dual observation with Geriatric Nursing Assistant (GNA) #8 in Resident #18's room to check the resident's call bell. When tested, the call bell triggered the signal outside the room to alert staff; however, the signal did not turn off when the wall button was pressed, which is a normal function of call bell lights. The resident reported having repeatedly requested repair of this issue, which had not been addressed. GNA #8 stated she would need to contact maintenance to turn off the light and report the issue.On 10/20/2025 at 11:56 AM, this surveyor conducted a dual observation with GNA #8 to test the call bells for Resident #19 and Resident #20. The call bell for Resident #19 functioned properly and triggered a signal when pressed. The call bell for Resident #20 did not function and failed to signal a light when pressed. GNA #8 stated she would notify maintenance of this issue.On 10/20/2025 at 2:10 PM, this surveyor conducted an interview with the Maintenance Director regarding call bell maintenance requests. The surveyor inquired whether any requests had been submitted for Resident #20's call bell. The Maintenance Director reviewed the TELLS system and confirmed that no work orders had been entered for the call bell in that room. When asked about Resident #18, he confirmed that a work order had been placed on 10/20/2025 at 11:54 AM for Call Bell not working. He stated that he planned to address and repair the issue following the interview. The surveyor also informed the Maintenance Director of the nonfunctioning call bell for Resident #20. He acknowledged the concern and confirmed that he would repair the call bells in both rooms.On 10/20/2025 at approximately 3:10 PM, the Maintenance Director reported to the surveyor that the call bells for Resident #18 and Resident #20 had been repaired.On 10/21/2025 at approximately 10:00 AM, this surveyor observed Resident #18's room and the resident reported that the call bell light had been repaired.On 10/21/2025 at 10:05 AM, observation of Resident #20's call bell indicated that it had been replaced. The resident was asleep at the time, and the call bell was within reach.On 10/21/2025 at 11:17 AM, this surveyor conducted an interview with the Administrator. The Administrator was informed of issues with the call bells for Resident #18 and Resident #20, including interviews with GNA #8 regarding nonfunctioning call bells, and Resident #18's report that prior requests for repair had not been addressed. The Administrator acknowledged the concern and stated that a call bell audit would begin that day to check every call bell in each resident room and ensure proper function.On 10/21/2025 at 1:34 PM, this surveyor conducted an interview with the Maintenance Director, who reported that he had begun the call bell audit for every resident room in the facility and provided documentation of the repairs completed. The documentation indicated that call lights for Resident #19, Resident #20, Resident #22, Resident #23, Resident #24, and Resident #25 had been identified as not functioning and were repaired by the Maintenance Director that day.