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	06/15/2026

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 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, policy review, and interview, it was determined that the facility failed to ensure that a resident remained free from abuse. This was evident for 1 (Resident #29) of 7 abuse investigations reviewed during the recertification and complaint survey.The findings include: On 6/11/26 at 10:47 AM, a review of facility-reported incident #2975907 revealed that on 4/6/2026, at approximately 3:20 AM, Resident # 29 allegedly sustained injuries during an interaction with Geriatric Nurse Assistant (GNA) #31.A review of Resident #29's medical record revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive impairment.According to a telephone interview conducted by the facility with GNA #31, Resident #29 exited his/her room in a wheelchair and approached GNA #31 in the hallway. GNA #31 stated that the resident grabbed his/her hand and repeatedly asked, Where is my table? GNA #31 reported telling the resident that he/she did not have the table; however, the resident continued to hold onto the GNA's arm tightly. GNA #31 stated, I had to pry my arm from the resident's grip. GNA #31 further stated that he/she did not notice any injury or bleeding to the resident's arm during the encounter and reported the incident to the night supervisor.The facility also obtained a statement from the night supervisor, Licensed Practical Nurse (LPN) #32, who reported that approximately 3:30 AM, Resident #29 came to the nurses' station and stated, The aide did this to me. LPN #32 observed skin tears with active bleeding to the resident's left arm.On 4/6/2026, the facility interviewed 12 other residents who resided on the same assignment as GNA #31. Two residents reported that GNA #31 was a little rough while providing care. When asked to clarify, the residents stated that GNA #31's hands were not gentle during personal care.A review of the Nurse Practitioner's progress note dated 4/6/2026 at 3:56 PM confirmed bruising and skin tears to Resident #29's left arm.A review of GNA #31's personnel file revealed a documented disciplinary action dated 6/12/2025 for performance misconduct, which stated that the employee was heavy-handed with residents during care.Further review revealed that GNA #31's employment was terminated on 4/15/26. The documented reason for separation included rude, discourteous, condescending, unprofessional, or otherwise socially unacceptable behavior toward customers, residents, or anyone in contact with the Company.A review of the facility's Abuse Prevention Policy, implemented on 3/14/23 and revised on 9/12/24, stated: The facility strictly prohibits abuse, mistreatment, neglect, or exploitation of all residents, or misappropriation of resident property. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.On 6/12/26 at 8:38 AM, during an interview, LPN #18 stated that when caring for residents with dementia who exhibit behavioral symptoms, staff were expected to use interventions to calm the resident and maintain the resident's safety. LPN #18 further stated that if a resident became physically aggressive by pulling or hitting staff, staff were expected not to pull away forcefully or strike the resident, but instead seek assistance from other staff members.On 6/12/26 at 9:30 AM, during an interview, the Assistant Director of Nursing (ADON) stated that she was unable to provide additional details because she did not conduct the investigation. The ADON confirmed that GNA #31 left a handprint on Resident #29's arm and was subsequently terminated.On 6/12/26 at 10:07 AM, the Director of Nursing (DON) was informed of the findings and acknowledged that the incident met the facility's definition of abuse.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to protect a resident's right to be free from misappropriation of property specifically involving the diversion of narcotic medication. This was evident for 2 (Resident #136 and Resident #137) of 2 resident Facility Reported Incidents reviewed for missing narcotic medications during the recertification/complaint survey.The findings include:1. On 6/09/2026 at 9:08 AM, the surveyor investigated the facility's self-report intake #2784380 which indicated that Resident #136 had 3 pills of a Narcotic medication (Oxycodone: medication prescribed for severe pain) missing on 2/18/2026. The investigation surmised that Staff #41 was asked to go to the Unit Manager's office because the Nursing Supervisor noted that he/she was repeating words during a conversation and had pin pointed pupils. While Staff #41 had gone to the office, Staff #42 and Staff #43 counted the narcotics in the cart that Staff #41 was assigned to throughout the shift. During the narcotic count it was noted that the Narcotic sign off sheet was last dated 2/18/2026 at 11:00 AM indicated 19 pills remaining, but the actual narcotic pill bubble pack had 16 pills present. This was immediately brought to the attention of Staff #41 and the DON. Staff #41 went to the cart and stated and wrote on the narcotic count sheet that she administered 1 pill at 3:00 PM and 1 pill at 6:00 PM but could not account for the other (1) missing pill. The Nursing Supervisor (Staff #43) interviewed Resident #136 who stated that her last pain medication was administered by the previous nurse, Staff #38 at 11:00 AM. The resident also stated that Staff #41 came in the room to say Hi, but did not administer any pain medication. Staff #41 could not account for the missing pill. A review of the Resident's medical record on 6/09/2026 at 10:32 AM revealed that Resident #136 was admitted to the facility on [DATE] and discharged on 2/21/2026. The resident had a Brief Interview for Mental Status (BIMS) score of 15. The resident had an order for Oxycodone oral tablet 15 MG, give 1 tablet by mouth every 4 hours as needed for pain rated 6-10/10 and the Medication Administration Record (MAR) did not have any documentation of Oxycodone tablets administered to Resident #136 by Staff #41.On 6/9/2026 at 12:04 PM, during an interview with Staff #6, the surveyor asked about the procedure for narcotic count on the shifts. Staff #6 stated that the narcotic count is done at the beginning and ending of the shift between the oncoming and off going nurse. The count starts with the number of physical narcotic cards on hand and compared to the number on the narcotic shift count sheet, then proceed to the individual cards with the resident's name and the number of pills remaining in each card. If there is a discrepancy, there is a recount, and if the count is not correct, notify the Unit Manager, the Nursing Supervisor, or the DON if necessary. When asked about narcotic administration, Staff #6 stated the nurse should document on the narcotic count sheet and the MAR when the medication is given and not at the end of the shift.2. A review of the Facility Reported Incident (FRI) # 2794677 indicated that Resident #137 had a total of two packets of Oxycodone 5 mg tablets bubble packs missing on 3/2/2026.1 pack had a total of 19 tablets remaining with the last dose given on 2/16/2026 at 6:30 PM.1 pack had a total of 22 tablets remaining on 2/20/2026 with the last dose given at 08:00 AM.Staff #37 reported in a written statement that on 3/2/2026 at approximately 11:05 PM that a handoff and narcotic count was done at the beginning of the shift with Staff #36, who worked a double shift 7AM-3PM and 3PM -11PM. During the count Staff #36 and Staff #37 confirmed that number of cards of Narcotics was 6. Staff #37 reported in her statement that during her rounds on the unit, no resident was discharged or transferred, therefore the number of cards of narcotics should have been 7. Staff #37 immediately notified the Nursing Supervisor who reviewed the medication log book and found the Narcotic sheet with 22 tablets of Oxycodone 5mg tab for Resident #137 lined through without an explanation or signature for destruction. Staff #36 had already exited the building, and the Nursing Supervisor reached out to the nursing agency and obtained the number to call Staff #36, who did not answer the phone. The DON stated in the investigation document that Staff #36 denied removing any medications outside of what was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered to the resident.On 6/11/2026 at 11:00 AM, a review of the medical record for Resident #137 revealed that the resident was admitted on [DATE] and discharged on 3/10/2026. The resident had a BIMS score of 15. The resident had an order for Oxycodone 5 MG tablets, give 1 tablet by mouth in the morning for pain, order date 02/16/2026 and discontinue date 02/20/2026. The surveyor noted that a medication sheet indicating 26 tablets were received on 2/17/2026 at 8:00 PM and the last date the medication was administered was 2/20/2026 at 8:00 AM with a remaining 22 tablets. There was a diagonal line drawn through the sheet. There were no signatures or initials on the sheet to indicate destruction of the medications. There was another order written to give oxycodone tablet 5 mg by mouth every 4 hours as needed for pain 6/10-10/10, order date 02/12/2026 and discontinue date 02/21/2026.On 6/11/2026 at 11:25 AM, in a review of Resident #137's MAR, there was no documentation of Oxycodone given for pain as needed for 02/12/2026 to 02/21/2026. However, the Narcotic count sheet indicated that 30 tablets were received from the pharmacy on 2/12/2026 at 8:00 AM. 1 tablet was administered on 2/12/2026 at 5:00 PM and 11:00 PM; on 2/13/2026 1 tablet was administered at 4:00 PM and 10:10 PM; on 2/14/2026 1 tablet was administered at 2:00 AM, 4:00 PM, and 11:00 PM; on 2/16/2026 1 tablet was administered at 2:00 AM, 11:00 AM, and 6:30 PM. The sheet had a diagonal line drawn through it and indicated at the bottom that 19 pills were destroyed with 2 different initials as witnesses.During further review on 6/11/2026 at 11:30 AM of the facility's investigation, the surveyor noted that the facility conducted an audit of the narcotic books and found that on the dates and shifts that Staff #36 worked from 2/27/2026 to 3/1/2026 that there were narcotic cards deducted from the shift count sheet. In addition, the narcotic administration count sheets had signatures and initials that did not match any staff members.On 6/11/2026 at 11:50 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA), the Assistant Director of Nursing (ADON), and the Unit Manager, Staff #5, who stated that they believed that drug diversion occurred based on their investigation of both incidents. The surveyor informed them that the incidents are a concern for misappropriation of property because the medication was prescribed and delivered to the Residents and could not be accounted for. The leadership team agreed, and stated that education was provided to the staff on the proper handling of controlled/double lock medications, and both nurses were reported to the Maryland Board of Nursing.

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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 a review of facility investigative materials, medical records, and staff interviews, it was determined that the facility failed to thoroughly investigate a self-reported incident. This was evident for one (incident report #3003592) of 21 reports reviewed during this annual survey.The findings include:On 6/10/26 at 2:08 PM, the surveyor reviewed self-reported incident #3003592. The review revealed that Resident #122 reported to the unit manager on 5/04/26 that his/her nurses had allegedly used inappropriate language.In an interview with Resident #122 on 6/08/26 at approximately 1:00 PM, the surveyor noted that the resident was alert and oriented. The resident's most recent Brief Interview for Mental Status (BIMS)-a short, standardized cognitive screening tool used primarily in long-term care settings to check memory, attention, and orientation-was conducted in April 2026, with a score of 15 out of 15, indicating intact cognitive function.Further review of the facility's investigation packet revealed that it contained no statement from Resident #122. Additionally, the facility identified that two nursing staff members were involved in this incident (Licensed Practical Nurse #48 and LPN #49). LPN #48's most recent abuse training was on 4/02/25, and LPN #49's most recent abuse training was on 1/10/24. However, there was no documentation indicating that LPN #48 and LPN #49 received corrective abuse training after this incident to prevent similar occurrences.In an interview with the Director of Nursing (DON) on 6/11/26 at 12:19 PM, the surveyor reviewed the facility's investigation documentation with her. She verified that there was no statement from Resident #122, who had reported the verbal abuse to the facility. The DON stated, The abuse training should be conducted right after the incident. She validated that there were no subsequent training records for LPN #48 and LPN #49.

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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. Based on medical record reviews and interviews with facility staff, it was determined that the facility staff failed to provide nursing care within professional standards of practice regarding safe medication administration. This deficient practice affected 1 resident (Resident #122) out of 6 residents reviewed for medication administration during the annual survey.The findings include:A review of Resident #122's medical records on 6/12/26 at 2:44 PM revealed that on 6/07/26, the resident's scheduled morning medications (ordered for administration between 7:00 AM and 9:00 AM) were significantly delayed and not administered until 4:16 PM.The delayed administration included a scheduled 9:00 AM dose of Tylenol (acetaminophen) 650 mg. A further review of the Medication Administration Record (MAR) showed that a second scheduled dose of Tylenol 650 mg (ordered for 1:00 PM) was documented as administered just three minutes later, at 4:19 PM. The records indicate that Resident #122 received a combined total of 1,300 mg of Tylenol within a three-minute interval, exceeding the maximum safe single dose of 1,000 mg for adults and posing a severe potential risk for medication toxicity.During an interview on 6/15/26 at 8:50 AM, the Director of Nursing (DON) stated that all medication administrations must be documented immediately after they are given to the resident. The surveyor reviewed Resident #122's MAR alongside the DON and pointed out that the two separate doses were administered concurrently, resulting in an unsafe single dose exceeding 1,000 mg. The DON validated the surveyor's concern and verified that the resident received an excessive single dose of acetaminophen at 4:19 PM.

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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. Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to ensure that residents received medications and care in a timely manner. This deficient practice affected 1 resident (Resident #122) out of 21 residents reviewed for care provision during the annual survey.The findings include:During the investigation of complaint #3036801 on 6/12/26 at 2:44 PM, a record review revealed that the complainant expressed severe concerns regarding Resident #122's care on 6/08/26, specifically alleging that the resident received delayed care.On 6/15/26 at 8:20 AM, the surveyor reviewed Resident #122's Medication Administration Record (MAR) and Treatment Administration Record (TAR). The review revealed that on 6/07/26, scheduled morning medications (ordered for administration between 7:00 AM and 9:00 AM)-which included a diuretic, Parkinson's medication, and blood pressure medications, some of which were scheduled for twice-daily administration-were not administered until 4:20 PM. There was no documentation within the medical record explaining why the medication administration was delayed by approximately eight hours.During an interview on 6/15/26 at 7:35 AM, Unit Manager #5 was asked whether Resident #122 had experienced any issues regarding delayed care. She stated that she was completely unaware of any issues regarding care delays for this resident.During an interview on 6/15/26 at 8:50 AM, the Director of Nursing (DON) stated that facility staff are required to administer medications within a standard two-hour window (one hour before or one hour after the scheduled time). The DON further explained that nurses are required to document the exact administration time in the MAR immediately after giving the medications. The surveyor reviewed Resident #122's MAR alongside the DON and shared the finding that the morning medications were administered more than eight hours late. The DON validated the surveyor's concern and verified the non-compliance.

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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. Based on observations, medical record reviews, and interviews with facility staff, it was determined that the facility failed to ensure residents remained free from accidents and hazards. Specifically, the facility failed to: 1) thoroughly assess residents who smoke to ensure their safety, and 2) implement timely interventions for residents experiencing ongoing altercations with peers. This deficient practice affected 2 out of 5 residents reviewed for smoking (Residents #108 and #122), and 2 out of 2 residents reviewed for resident-to-resident altercations (Residents #56 and #81) during this annual survey.The findings include:1) Failure to Assess and Ensure Smoking SafetyDuring the entrance conference on 6/08/26 at 8:20 AM, the Assistant Director of Nursing (ADON) stated, This is a smoke-free building. However, alert and oriented residents can go outside of the facility's property after signing in and out on the Leave of Absence (LOA) form.On 6/09/26 at 1:36 PM, facility staff provided a list of five current smokers. A review of these residents' medical records revealed the following:-Resident #108: The resident's Brief Interview for Mental Status (BIMS) score on 5/15/26 was recorded as 00 (indicating severe cognitive impairment). The resident's previous BIMS scores consistently ranged between 12 and 13 out of 15 (indicating mild to no impairment). There was no follow-up documentation regarding this significant cognitive decline.-Additionally, Resident #108's medical record showed that the most recent smoking assessment was conducted over a year prior, on 4/15/25. There was no current documentation addressing how the facility assessed the resident's ability to smoke safely.On 6/09/26 at 1:40 PM, Resident #108 and Resident #122 were observed smoking outdoors behind a designated line marking the facility's property boundary. During an interview at that time, Resident #108 stated that there were no rules or limitations regarding smoking, adding, I can be here anytime I want to smoke. I have not signed the form recently.On 6/09/26 at 1:54 PM, Receptionist #7 stated during an interview that smokers are required to sign the LOA form before going outside to smoke. A review of the sign-out sheet, titled Release of Responsibility for Leave of Absence (for the week of 6/07/26 to 6/13/26), revealed columns for date, departure time/signature, destination, phone number, return date/time, and return signature. The log contained only seven signatures-all from the same individual, whose name was illegible-and lacked any of the other required tracking information.On 6/09/26 at 2:00 PM, Resident #108 was observed lying in bed while receiving oxygen via a nasal cannula. The resident confirmed keeping a cigarette lighter and cigarettes inside the room.On 6/09/26 at 1:45 PM, a medical record review for Resident #122 revealed that their most recent smoking assessment was also dated 4/15/25. Resident #122 confirmed that they had not filled out the LOA log recently for smoking.During an interview on 6/12/26 at 8:18 AM, the Director of Nursing (DON) stated that because the facility is smoke-free, they do not maintain a specific smoking policy or procedure. However, the DON agreed that the facility must track and evaluate a smoker's cognitive level to ensure they are safe to go outside to smoke independently. The DON reviewed the medical records for Residents #108 and #122 and verified that both residents required updated assessments to clear them for independent smoking.2) Failure to Implement Interventions for Resident AltercationsDuring a review of self-reported incident #3019517 on 6/11/26 at 1:00 PM, record review revealed that Resident #81 reported to the Administrator that his/her roommate had allegedly hit [them] on the right hand and in the stomach on 5/20/26 at 10:00 AM. The facility's internal investigation noted that the resident had visible bruising on the right hand and stomach.A review of Resident #81's medical record revealed that the resident had reported several conflict episodes with his/her roommate prior to the injuries noted on 5/20/26:-On 4/29/26: Resident #81 reported that his/her roommate (Resident #56) used the phone all night, causing severe disruption.-On 5/01/26: A progress note recorded another verbal/physical conflict, including claims that Resident #56 blocked the pathway to the restroom and spoke loudly while Resident #81 was trying to sleep.-On 5/07/26: Another conflict occurred between Resident #56 and Resident #81 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding light and noise levels in the room.-On 5/14/26 at approximately 2:00 PM: Resident #81 was observed throwing him/herself out of a wheelchair, resulting in a transfer to the hospital for an emergency evaluation. While at the hospital, Resident #81 insisted that the roommate and [they] have been having difficulties getting along for a while, and stated that the roommate may have pushed [them] to the ground.A review of Resident #81's psychology notes dated 5/13/26 revealed documentation stating the provider encouraged a room move to a safe room and encouraged [the resident] to inform staff of future roommate issues. Despite this recommendation and the ongoing history, no interventions were implemented by the facility to protect Resident #81 until after the physical assault and resulting injuries were reported on 5/20/26.During an interview with the DON on 6/11/26 at 3:12 PM, the surveyor reviewed the medical and administrative records of Resident #81 and Resident #56 with her. When asked what interventions had been provided to ensure resident safety during these ongoing disputes, the DON stated that both residents had been offered room changes but had refused them. However, a comprehensive review of both residents' medical records revealed zero documentation showing that room changes were ever officially offered or refused.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on a review of medical records and staff interviews, it was determined that the facility failed to provide necessary care and follow required clinical protocols for a resident with an indwelling urinary (Foley) catheter. This failure was identified in one resident (Resident #122) out of two residents reviewed for Foley catheter care during the annual survey.The findings include:On 6/08/26 at 1:03 PM, the surveyor investigated a complaint received from an outside source. The review revealed that Resident #122 did not receive appropriate Foley catheter care from the facility staff.A review of Resident #122's medical records on 6/09/26 at 11:27 AM revealed that the resident was evaluated by Urology on 1/23/26. The consultation note from the urologist stated, Remove catheter and have him/her changed every 4 hours. and consult one of our MDs for suprapubic catheter placement. However, there was no subsequent follow-up appointment documented in the facility's system.During an interview with Unit Secretary #8 on 6/09/26 at 12:33 PM, she verified that the most recent urology consultation occurred on 1/23/26. When the surveyor asked whether Resident #122 had any follow-up appointments scheduled after the January 2026 visit, Unit Secretary #8 confirmed that no further follow-up had been arranged, stating, I just talked to the resident, he/she did not like [the] suprapubic catheter.Further review of Resident #122's Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that the resident's Foley catheter was documented as changed on 3/20/26, 3/22/26, and 6/02/26. However, progress notes indicated additional catheter changes occurred on 5/14/26 and 6/01/26 without being documented on the MAR or TAR with various sizes of catheter.During an interview with the Director of Nursing (DON) on 6/11/26 at 12:29 PM, the surveyor shared the aforementioned concerns. The DON stated that Resident #122 had frequent issues regarding Foley catheter care, including refusing care, complaining of discomfort, and expressing false beliefs that the catheter was damaged, leaking, or contaminated. The DON stated, I agree all of those episodes should be documented in his/her chart.

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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 record review, interview and Facility Reported Incident (FRI) #2980586, it was determined that the facility failed to ensure that pain management was provided to each resident with professional standards of practice. This was evident for 1 (Resident #139) of 3 residents reviewed for pain management during the survey process.Findings included:Non-pharmalogical interventions are identified as an alternative method of treatment for a medical concern without the use of medication. This could include physical, psychological, and lifestyle interventions designed to reduce pain and improve quality of life. The CDC's 2022 Clinical Practice Guideline for Prescribing Opioids emphasizes non-pharmacological, non-opioid therapies as the first line of treatment for subacute and chronic pain.On 06/12/2026 at approximately 9:00 AM, a review of FRI #2980586 revealed that on 04/07/2026 at approximately 3 PM Resident #139's family member reported that the resident appeared to be over-medicated.On 06/18/2026 at 09:44 AM, in an interview with Staff #5 (unit manager), she was asked about the resident's pain management and Staff #5 explained that Resident #139 reported pain and as a result the resident was treated for pain. Upon the family member's concern, the resident's pain medication was reviewed.On 06/15/2026 at 10:35 AM, in a follow-up interview with Staff #5, she reported that the resident's pain medication (oxycodone) was later decreased from 4 times per day to 2 times per day due to drowsiness.On 06/15/2026 at approximately 10:36 AM, a review of a pain assessment completed on 04/06/2026 03:17PM revealed a recommendation, new medications added: Oxycodone 5 mg PO four times per day Interventions: Patient reported inconsistent administration of Oxycodone. Order placed for routine Oxycodone will follow up.On 06/15/2026 at approximately 10:40 AM, a review of the resident's physician order and Medication Administration Record (MAR) revealed that the resident had the following pain medication order:-First, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Moderate to Severe Pain -Order Date: 04/02/2026; pain medication administered as order on 04/3/2026, 04/4/2026, and 04/6/2026. -Then, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth four times a day for persistent pain -Order Date-04/06/2026 1555 -D/C Date- 04/07/2026 1701; pain medication administered as ordered (3 separate dose) and the 4th dose was held for drowsiness.-Final change, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth two times a day for persistent pain -Order Date- 04/07/2026 1701 -D/C Date-04/10/2026 1524; pain medication administered as ordered (4 doses).Non-Pharmacological Intervention(s) used before PRN (as needed) Pain Medication or before PRN anti-depressant, anti-anxiety, anti-psychotic or sedative/hypnotic medication Document by number:1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction 9 toilet 10 ambulate 11 provide food/drink 12 educated 13 one: one 14 other -add to PN the description -Order Date04/01/2026.On 6/15/2026, a review of the medication administration record revealed that pain monitoring was completed at least once per shift and the documentation revealed that the resident was unable to communicate pain level most of the time.On 06/15/2026 in an interview with Staff #5, she was asked how pain level was assessed and she reported that pain assessment for non-verbal residents included signs such as grimacing during care and moaning. She reported that the pain assessment in the computer would indicate if the resident was communicative or non-communicative.On 06/15/2026 at approximately 10:41 AM, a review of Resident #139's progress notes written on 06/15/2026 at 4: 49 PM revealed: Resident is drowsy, opened eyes when called name. Also, a change of condition assessment for was completed on 06/15/2026 at 9:51 PM due to: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse).On 06/15/2026 10:44 AM. The Director of Nursing (DON) notified that the resident had orders for PRN non-pharmacological interventions prior to the administration of PRN pain medication. The resident received several oxycodone administrations for pain; however, there was no documentation to support that the facility implemented the non-pharmacological intervention as ordered to aid with pain management prior to administering narcotics.

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	06/15/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interviews, it was determined that the facility failed to 1) ensure the accurate documentation of controlled medications administered to residents by maintaining consistency between the Medication Administration Record (MAR) and the controlled substance record (narcotic book), and 2) ensure proper pharmaceutical procedures for the destruction of controlled substances. This was evident for 2 (Residents #71 and #108) of 3 residents reviewed for controlled medication administration and 1 (Resident #137) of 1 resident reviewed in a Facility Reported Incident (FRI) for destruction of discontinued narcotic medications during the recertification survey. The findings includes: 1) On 6/09/2026 8:55 AM, an interview with Registered Nurse (RN) #6 revealed that the narcotic book was updated each time a controlled medication was administered and was reviewed during shift report. On 6/09/2026 at 9:26 AM, a review of the narcotic book and corresponding MARs for the month of June 2026 revealed the following: -Resident #108 had a physician's order for Morphine Sulfate Oral Solution 20 milligrams (mg) per/5 milliliters (ml) (Morphine Sulfate) Give 6.5 ml by mouth every 4 hours as needed for pain rated 5-10/10. Review of the narcotic book indicated the medication was administered on 6/01/2026 at 3:00 AM, 6/03/2026 at 1:05 AM, and 6/04/2026 at 2:45 AM and 5:00 PM. However, the MAR did not contain documentation that the medication was administered on 6/01/2026 at 3:00AM. -Resident #71 had a physician's order for Oxycodone Hydrochloride (HCl) Oral Tablet 10 mg (Oxycodone HCl), administer one tablet by mouth every 6 hours as needed for severe pain rated 7/10-10/10; hold for sedation, altered mental status, or change in condition. Review of the narcotic book indicated the medication was administered on 6/01/2026 at 1:30 PM, 6/02/2026 at 4:00 PM, 6/03/2026 at 1:20 PM, 6/05/2026 at 4:30 PM, 6/06/2026 at 12:46 AM, 10:00 AM, and 12:29 PM, and on 6/08/2026 at 10:00 AM. However, the MAR lacked documentation of administration on 6/05/2026 at 4:30 PM. On 6/09/2026 at 10:57 AM, an interview with the Assistant Director of Nursing (ADON) revealed that nurses were expected to document controlled medications in both the narcotic book and the MAR immediately after administration. The DON was notified of the above findings and acknowledged the concerns. 2) On 6/10/2026 at 8:36 am, during the investigation of a Facility Reported Investigation # 2794677, the surveyors noted a copy of a narcotic count sheet with a diagonal line drawn through it with no licensed nurse's signatures or witness verification that the medication was destroyed. The drug on the narcotic sheet was Oxycodone 5mg, 1 tablet by mouth every 4 hours as needed for pain. The label had the name of Resident #137 and a prescription #2189324. The narcotic sheet indicated that on 2/17/2026 at 8:00 PM, 26 tablets were received. On 2/18/2026, 1 tablet was marked as waste at 07:14 AM, and 1 tab was administered at 09:00 AM; on 2/19/2026, 1 tablet was administered at 08:00 AM; on 2/20/2026, 1 tablet was administered at 08:00 AM, which left 22 tablets. A medical record review for Resident #137 was conducted on 6/10/2026 at 09:00 AM, that revealed (continued on next page)

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	215143	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order for oxycodone oral tablet 5 mg by mouth in the morning for pain. The order was written on 02/16/2026 and was discontinued on 02/20/2026. The Medication Administration Record (MAR) had documentation that the medication was administered as ordered from 6/17/2026 to 6/20/2026, therefore the remaining 22 tablets were to be destroyed. In an interview on 6/11/2026 at 11:50 AM, the Interim Director of Nursing stated that medications are wasted/destroyed by two licensed nurses. They document their signatures or initials on the narcotic count sheet and another sheet that goes to the unit Managers. On 6/15/2026 at 08:20 AM, an interview was conducted with the unit manager, Staff #5. The surveyor asked about the destruction of narcotics, and Staff #5 stated that when a medication is discontinued, or a resident is discharged or transferred, there is a destruction sheet that is filled out and scanned to the drug agency. The narcotic sheet can have a line drawn through it with the bottom area filled out as drug discontinued or drug destroyed with 2 nurse's signatures. Staff #5 provided the surveyor with an example of a controlled destruction report. It read, Forward this completed form, within 10 days of the destruction, to the office of Controlled Substances Administration (OSCA) via email. Do not fax destruction report. it had a column for the dosage form (tablet, liquid etc), quantity, drug name, strength, prescription number and the pharmacy name that provided the medication. On 6/15/2026 at 08:35 when Staff #5 was asked about the discontinued narcotic medication for Resident #137 on 2/20/2026, and the narcotic sheet that was lined through without any nurse signatures, Staff #5 could not explain if the medication was destroyed because here was no documentation on the controlled substance report. Staff #5 admitted that the narcotic sheet was found on 3/1/2026 during an audit for a possible drug diversion. On 6/15/2026, further review of the investigation noted that, following the reveal of the drug diversion, an audit of the narcotic count sheets and narcotic cards shift count sheet were to be conducted for 12 weeks and results reported to QAPI. The last audit identified was in April 2026, and there was no indication that results were reported to QAPI. During a follow up interview with the Interim DON on 6/15/2026 at 09:20 AM, the DON was made aware that there was a concern regarding drug destruction when narcotics are discontinued. The DON agreed with the concern and stated that the facility had provided education to all the facility nurses regarding the proper handling of controlled/double locked medication, and that education was ongoing.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews, and record review, it was determined that the facility failed to ensure that medications were administered as ordered. This was evident for one resident (Resident #5) out of 6 residents reviewed during the annual survey.The findings include:A review of facility self-reported incident #3016788 on 6/10/26 at 3:48 PM revealed that Resident #5 received a double dose of Retacrit (a prescription medication that stimulates bone marrow to produce red blood cells) on 5/15/26.A review of Resident #5's medical records on 6/11/26 at 7:30 AM revealed a cardiology follow-up progress note dated 5/13/26, which stated, Hematology has recommended that we increase his/her Retacrit from 20K units q weekly to 40K units q weekly.Further review of Resident #5's medical records noted that a physician's order was entered on 5/15/26 at 7:00 AM for Retacrit 40K units every shift for anemia. As a result, the medication was mistakenly administered twice on 5/15/26: once at 7:00 AM and again at 3:00 PM.The facility's incident investigation included interviews and statements from the nursing staff. Nurse Supervisor #3 reported, The order was to be entered once weekly, and I unknowingly had entered per shift not per week, which I was not aware of until after I had left the building/work. Licensed Practical Nurse (LPN) #35 provided a written statement on 5/21/26, noting, A Retacrit order popped up on my shift (5/15/26, 3:00 PM-11:00 PM) to administer, I administered Retacrit injection.During an interview with Unit Manager #5 on 6/11/26 at 9:32 AM, she stated that the facility's night nurse discovered the transcription error and reported the incident.On 6/11/26 at 12:17 PM, the Director of Nursing (DON) was interviewed. The DON verified and validated the findings.