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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hagerstown	14014 Marsh Pike Hagerstown, MD 21742

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations and interviews it was determined that the facility staff failed to maintain a homelike environment as evidenced by a stained ceiling tile in a resident's room and damaged drywall behind a residents' bed. This deficient practice was evidenced in 2 (#301, #302) of 2 rooms located on the unit [NAME] that were assessed during the complaint survey.The findings include:On 03/30/26 at 11:41 am while assessing the rooms that were affected by the faulty sprinkler system with Maintenance Director # 5 the surveyor observed a water-stained ceiling tile in room [ROOM NUMBER]. When the surveyor entered room [ROOM NUMBER] the surveyor observed the drywall behind Bed-B was damaged.On 03/30/26 at 10:54 am during an interview with Maintenance Director #5 the surveyor asked how often the resident rooms are checked for maintenance concerns. Maintenance Director #5 verbalized weekly and monthly audits are performed. If there are maintenance concerns the staff puts a work order into TELS. The maintenance department did not receive a work order about the stained tile or damaged drywall behind the bed. They do certain things regularly, but they also rely on work orders from the staff.On 03/30/26 at 11:04 am the surveyor asked Director of Nursing #2 was a work order submitted for the damaged drywall and stained ceiling tile. DON #2 verbalized they didn't think a work order was submitted for the maintenance issues. Geriatric Nursing Assistant #7 verbalized they did not notice the damaged drywall in room [ROOM NUMBER]-B. The surveyor observed GNA#7 walk into room [ROOM NUMBER]. Registered Nurse #6 verbalized they didn't pay attention to the maintenance concerns during rounds that morning.

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 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 record review and interview it was determined that the facility staff failed to clarify a verbal order for a resident to receive intravenous fluids. This deficient practice was evidenced in 1(Resident #2) of 5 medical records reviewed for medical staff adhering to physician orders during the complaint survey.The findings include:On 03/30/26 at 11:17 am a review of Resident #2's electronic health record (EHR) revealed on 02/11/26 at 10:57 am the resident was ordered Lactated Ringers 1 liter intravenously 75 ml/hour for 2 days for dehydration. The fluids were signed off as given on 02/11/26-02/12/26. There was no documentation to verify the fluids were received on 02/13/26. On 03/30/26 at 12:11 pm during an interview with Director of Nursing (DON) #2 the surveyor reported the resident did not receive their full treatment of Lactated Ringers according to the medication administration record (MAR). DON #2 verbalized Resident #2 was supposed to receive 2L in 24 hours and then 1L the following day. The NP wrote the order; the whole order was supposed to be for 2 days. Two liters the first day and 1liter the second day. The surveyor asked why the staff didn't clarify the order. DON #2 verbalized the order was poorly written. The order was followed but the way the order was written was confusing. The surveyor was provided a copy of Nurse Practitioner (NP) #9 note that was written on 02/11/26 at 12:07 pm. A review of NP #9 note revealed on page #5 in paragraph #2 it was written the resident was started on Lactated Ringers IV at 75cc/hour for 2 liters on 02/11/26. Continue IV fluids for 48 hours. On 03/30/26 at 2:51 pm during an interview with NP#9 they verbalized being uncertain how the order was transcribed. The surveyor made NP #9 aware their note indicated the order was for the resident to receive IV fluids for 48 hours beginning on 02/11/26. NP #9 verbalized their note was a typo. When the nurse started a new bag of IV fluids a new order was written in error.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, it was determined that the facility failed to ensure that their resident received care and treatment for wounds. This was evident for 1 (Resident #1) of 1 resident reviewed for wounds.The findings include:A medical record review for Resident #1 on 3/27/26 at 11:12 AM revealed a discharge summary from the hospital documented the resident had talar osteomyelitis of the left foot. It was noted that wound care was consulted and applied a treatment with a dry sterile dressing and wrapped with kerlix and planned to consult the resident's podiatrist. There were no other wounds listed and no treatment orders. A review of the facility's nursing admission note dated 11/20/25, revealed the resident had the following wounds on his/her left foot: a scab on the left ankle, a sore on left foot, and a sore on left heel. On 11/20/25 attending physician #11 conducted a history and physical and a review of the notes revealed they documented the same exact note as the discharge summary regarding the talar osteomyelitis. However, he failed to mention any other wounds. During his physical exam he noted for the skin there were no rashes, lesions, or nodules. He failed to ensure that the resident had treatment orders for the wounds found by the admitting nurse. A review of the wound care notes revealed that the first visit they conducted with Resident #1 was on 12/1/25 and following this visit treatment was initiated and continued. The wound nurse practitioner documented that the resident had a venous ulcer (a wound caused by lack of blood flow) on the left medial malleolus (outer ankle bone), a left planter diabetic foot ulcer (a complication of diabetes that causes breakdown of the skin and deeper tissue due to loss of sensation and decreased blood flow to the area), and an unstageable pressure ulcer (caused by prolong pressure applied to that area causing decreased blood flow and damage to the skin and underlying tissue) on the left heel. The wound NP started treatment on those wounds on 12/1/25, 10 days after the resident had been admitted to the facility. The surveyor attempted to contact the admitting nurse, Licensed Practical Nurse (LPN) #12, but was unsuccessful. An interview with attending physician #11 on 3/30/26 at 1:10 PM revealed that he had not assessed the wounds on the resident's left foot or provided a treatment order because they have a wound specialist that takes care of the wounds. He further stated that he doesn't have time to see the resident for wound care too. The Director of Nursing (DON) was interviewed on 3/30/26 at 1:22 PM revealed that the nurse should have read the discharge instructions and clarified the order for the wound that was mentioned. In addition, they should have notified the physician to get an order for the other 2 wounds that were found on the day the resident was admitted . When asked about contacting the nurse she reported LPN #12 had been terminated due to concerns with his nursing care.