STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215181	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Snf LLC	1300 Windlass Drive Middle River, MD 21220

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 14894 Based on staff interview, clinical record review, and an investigation into Intake #MD00205003, it was determined that the facility staff failed to ensure residents right to determine who speaks for them is respected. This was evident for 1 (#128) out 44 residents in the survey sample. The findings include: A review of Resident #128's clinical record revealed the resident was admitted to the facility with the assistance of a granddaughter. The facility was informed that the resident had a Medical Power of Attorney form that was signed on 3/15/24 appointing the granddaughter as the Health Care Agent. The granddaughter got a second signature on 3/18/24. The facility as of 3/20/24 was still contacting the resident's son. Social services wrote a late note on 3/21/24 at 09:13 AM detailing the recent family history of the resident and the note makes it clear that the resident wants support from the granddaughter not the son. This surveyor interviewed the Regional Director of Clinical Services prior to the survey team's exit from the facility and we discussed the importance of ensuring that the proper family contact is respected.

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 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** 49815 Based on observation and facility staff interview, it was determined that the facility failed to have a safe/clean/comfortable/homelike environment. This was found to be evident in 6 out of 8 Resident rooms observed by the surveyors during the tours of the facility. The findings include: 1. During the tour of the facility on 9/30/2024 at 10:45 AM the surveyor observed the following items in need of repair: the sink faucet in room [ROOM NUMBER] was missing a handle for the warm water, the cove basing in room [ROOM NUMBER] was not secure to the wall underneath the sink, one of the closets in room [ROOM NUMBER] was missing a drawer, and the walls marred in rooms 100, 112 and 114. At 9:20 AM on 10/7/2024 the surveyor toured nursing unit 100 with the Nursing Home Administrator (NHA) and the Maintenance Director. The NHA and the Maintenance Director observed room [ROOM NUMBER] and room [ROOM NUMBER] with the surveyor and acknowledged that these two areas required repair for the missing drawer and the unsecured cove base. During the observation on 10/7/2024 at 9:20 AM, the surveyor interviewed the Nursing Home Administrator (NHA) and the Maintenance Director and asked if they were aware of these two items that needed repair and what the expectation was for repair of those items. The NHA and the Maintenance Director stated that they were unaware of these two items that needed repair and that these items would be fixed. The Nursing Home Administrator (NHA) stated that the facility uses the TELS platform which is a computer-based system used by all facility staff for documentation of items that needed repair. In a follow-up interview with the Maintenance Director on 10/7/2024 at 9:45 AM, the surveyor addressed the marred walls observed in the Resident rooms. The Maintenance Director stated that he was aware of the marred walls and had a plan in place for repair of these marred walls in the Resident rooms. At 11:00 AM on 10/16/2024 the surveyor toured room [ROOM NUMBER] with the Director of Nursing. The Director of Nursing observed the handle for the warm water missing from the faucet and acknowledged that this faucet needed to be repaired. The Director of Nursing stated that she would have this documented in TELS for repair to be done by Maintenance. 14894 2. During tours of the facility this surveyor observed several environmental issues. On 9/30/24 at 9:30 AM observation of room [ROOM NUMBER] revealed that the baseboard molding was coming off of the wall opposite the residents' beds and the drawer face on the bottom of the armoire was off. On 9/30/24 at 10:30 AM observation of room [ROOM NUMBER] revealed the floor around bed B was sticky. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 10:00 AM observation of room [ROOM NUMBER] revealed the floor around bed B was still sticky.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on record review, review of complaint intake MD 00209581 and staff interview, it was determined that the facility failed to implement the grievance process as evidenced by the failure to initiate grievances and to resolve complaints. Additionally, the facility staff failed to ensure the residents' right to voice grievances with respect to care/ treatments and the concerns of staffs' behaviors regarding their facility stay. This was evident for 1 (Resident# 144) out of 20 residents reviewed for facility complaint reviews during an annual survey. The findings include: Record review, on 10/11/24 at 10:55 AM, revealed that Resident #144 filed a complaint to the Office of Health Care Quality (OHCQ) with MD 00209581 and emailed the Administrator at the same time, on 9/9/24, about staff concerns during the weekend. The resident indicated that a meeting was scheduled for 9/10/24 and he/she did meet with the Administrator about the grievances. However, there was no action taken and the resident was discharged on [DATE]. During the interview, on 10/11/24 at 02:00 PM, the Administrator stated that he received an email complaint about the staff delaying a smoking session and staff were argumentative loudly towards Resident #144. The Administrator confirmed that he did not enter a grievance after the meeting nor had a corrective plan. Record review, on 10/11/24 at 2:45 PM, of the facility's Grievances/Complaints, Recording and Investigation Policy revealed that it clearly stated All grievances and complaints filed with the facility staff will be investigated and corrective actions will be taken to resolve the grievances. The Administrator was the Grievance Officer/Designee. During interview, on 10/11/24 at 3:58 PM, the Regional Director of Clinical Operations (RDCO) was informed that it was a concern that the facility staff failed to implement the grievance process. The RDCO expected that all facility staff need to initiate the grievances immediately and follow through the Grievances/ Complaints process timely based on the facility's policy.

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on resident interview, staff interview, clinical record review, and a review of the facility investigation of intake #MD00207612, it was determined that the facility staff failed to ensure residents were free from abuse. This was evident for 1 (#97) out of 6 residents reviewed for abuse. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Actual Harm Past Non-compliance (PNC). The findings include: This surveyor started an investigation into intake #MD00207612 on 10/2/24. It was revealed that on 7/12/24 at 8:30 AM, Geriatric Nursing Assistant (GNA) #8 was providing AM care to Resident #97 but the resident was resisting her. She asked GNA #9 for assistance. GNA #9 entered the room and held the resident's arms while GNA #8 began changing the resident. The resident got an arm free and hit GNA #9. GNA #9 responded by punching the resident 2-4 times in the face. GNA #8 ran out and got the Unit Manager. The roommate, Resident #31, witnessed the incident. Further review revealed that Resident #97 had a facial injury just below the left eye as a result. Staff evaluated the resident after the incident. Resident #97 was evaluated as stable and safe. Resident #97 was also evaluated for psychosocial distress. The resident's responsible party was told on 7/12/24 at 8:30 AM. On 7/17/24, a facility-wide abuse interview/audit was conducted. GNA #9 was terminated and reported to the Maryland Board of Nursing (MBON). The statements of the two GNA's were reviewed on 10/7/24. GNA #8's statement to the police: I was attending to [Resident #97's room number]. As I was putting on [his/her] clothes. [He/She] started to kick and scream. I then stop[ped] doing [him/her] and went to ask [name of GNA #9] to help me get [him/her] changed and dress. The patient still began to kick and fight. [Name of GNA #9] was holding [him/her] down. [Name of GNA #9) then strike [him/her] in the face. The patient started to yell. I looked at the patient's face and [his/her] eye started to bleed. I went to report to [name of unit manager] immediately. GNA #9's statement was: At about 8 AM this morning another GNA asked me to assist her to dress the resident. I immediately moved to assist [him/her] as [he/she] started kicking and punching myself and [GNA #8] and I told [him/her] to stop while [he/she] continue to kick us and punch us then I hold [his/her] hand to prevent [him/her] from hurting us and asked [GNA #8] to put on [his/her] pants and shirt while we get [him/her] up as the resident keep on yelling in the process [his/her] nails cut [his/her] face. This surveyor interviewed GNA #8 on 10/7/24 at 11:40 AM. She said that she had the resident that day. She stated she was in the resident ' s room and declared that [he/she] is a fighter. She said she asked [name of GNA #9] to help her. She said he held the resident down by both hands while she put the resident ' s pants on. She stated that GNA #9 hit the resident in the eye twice. The resident ' s roommate yelled you didn ' t have to hit [him/her]. She saw that the resident had a cut just below the eye, left the room, and told the Unit Manager immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	This surveyor interviewed the former roommate on 10/07/2024 at 1:28 PM. Resident #31 said the male aide held the resident down while the female changed the resident's pants, he held the resident's hands down across the chest, at some point the resident got free and started hitting the male aide. The male aide punched the resident four times [Roommate demonstrated the punching by punching the air four times]. The female aide let go and she said, I don ' t want any part of this. She left the room and talked to the Unit Manager. This surveyor interviewed the Regional Director of Clinical Operations on 10/8/24 at 1:15 PM. Informed him the survey team reviewed the intake, reviewed the facility's investigation, conducted interviews, and determined that the resident was harmed. The Administrator was interviewed on 10/9/24 at 1:29 PM. He said as soon as he arrived at 8 AM the nurse came to him and said you need to handle this. He said they suspended the GNA after they got a statement. He added that he instituted a mass facility-wide questionnaire for all the residents. This surveyor interviewed the Regional Director of Clinical Operations and the Administrator on 10/11/24 at 8:00 AM. Explained that the abuse had been substantiated and that the resident was harmed. Both said they agreed that there was abuse and confirmed that an investigation was conducted. The investigation included a whole house audit of interviewable residents. They confirmed the alleged perpetrator was terminated and they educated the staff. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Actual Harm Past Non-compliance (PNC).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure that MDS (Minimum Data Set) assessments were coded accurately for Residents. This was found to be evident for 5 Residents (#41, #77, #119, #133 and #118) out of 5 Residents reviewed for accuracy of MDS assessments. The findings include: 1) The surveyor observed Resident #41 sitting on the side of her bed on 10/1/2024 at 10:16 AM with a Foley catheter in use. Resident #41 stated to the surveyor that he/she has a catheter. The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of Long-Term Care Nursing Facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. A record review of Resident #41's medical record was completed by the surveyor at 8:05 AM on 10/4/2024. The medical record review revealed that the Admission MDS dated [DATE] Section H0300 Urinary Incontinence indicated that Resident #41 was Frequently incontinent, and Not rated, resident had a catheter was not coded. Further review of the medical record for Resident #41 revealed that the Quarterly MDS dated [DATE] Section H0300 Urinary Incontinence indicated that Resident #41 was Occasionally incontinent, and Not rated, resident had a catheter was not coded. Review of Resident #41's care plan indicated that resident has a catheter for urinary retention. Review of Resident #41's physician orders revealed that resident had an order for Indwelling Foley catheter for obstructive uropathy. 2) On 10/9/2024 at 8:20 AM the surveyor conducted a record review of Resident #77's medical record. The chart review revealed that Resident #77 had redness to the sacrum (the large, triangular bone that forms the base of the spine and the back wall of the pelvis) on the Admission Evaluation completed 9/8/2024. Resident #77's care plan indicated that resident had actual impairment to skin integrity related to sacral redness. Review of the physician orders revealed that there was an order dated 9/9/2024 for Apply foam dressing to sacrum for protection every day shift for wound care. Review of the progress notes - Skin Observation Weekly dated 9/9/2024 to 10/1/2024 indicated Weekly skin observation completed. No skin concerns noted. Further review of the medical record revealed that the Medicare Admission MDS dated [DATE] Section M0100 Determination of Pressure Ulcer/Injury Risk indicated that Resident has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing/device. The Licensed Practical Nurse (LPN) MDS Coordinator #23 completed a modification to existing record for the Medicare Admission MDS dated [DATE] on 10/14/2024 at 8:41 AM Section M0100 and did not code that Resident has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing/device. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) The surveyor completed a closed record review for Resident #119 on 10/11/2024 at 9:02 AM. The closed record review revealed as documented in the progress notes that Resident #119 was discharged to custody of the County Police Department in stable condition on 7/26/2024. Further review of the medical record revealed that the Discharge Return not Anticipated MDS dated [DATE] Section A2105 Discharge Status indicated that Resident #119 was discharged Home/Community, and Not listed was not coded. The LPN MDS Coordinator #23 completed a modification to existing record for the Discharge MDS dated [DATE] on 10/14/2024 at 8:33 AM Section A2105 and did not code Home/Community but coded Not listed. The surveyor conducted an interview on 10/11/24 at 10:06 AM with the LPN MDS Coordinator and the Director of Nursing (DON) with the Regional Director of Clinical Operations present. The surveyor conveyed that the MDS for Residents #41, #77 and #119 were not coded accurately. The LPN MDS Coordinator #23 and the Director of Nursing (DON) acknowledged that the MDS' were not coded accurately. 4) On 10/16/2024 at 8:15 AM the surveyor reviewed a closed medical record for complaint MD#00194358 for Resident #133 who discharged from the facility on 7/7/2023. During the medical record review, the surveyor identified that Resident #133 had a care plan for risk for falls related to history of stroke. Further review of Resident #133 revealed that the Resident had a fall on 6/19/2023 as indicated on the SBAR/INTERACT Communication form which is an assessment tool documented by nursing for Resident change in condition. The surveyor reviewed the Discharge Return Not Anticipated MDS assessment dated [DATE] and Section J1800 was coded that Resident #133 did not have any falls. The surveyor interviewed the Director of Nursing (DON) at 11:30 AM on 10/16/2024 and conveyed to DON that Resident #133 had a fall on 6/19/2023, and that the Discharge Return Not Anticipated MDS dated [DATE] was coded that Resident did not have any falls. The DON acknowledged that the Resident did have a fall on 6/19/2023 and the MDS was not coded accurately. On 10/18/2024 at 11:00 AM, the surveyor conducted a follow-up review of Resident #133's MDS section of the medical record. This follow-up review revealed that there was a Modification of the Discharge Return Not Anticipated MDS dated [DATE]. This modification was completed on 10/17/2024 at 7:11 AM by the LPN MDS Coordinator #23 for Section J1800 and J1900 which indicated that the resident had a fall with injury. The surveyor conducted a follow-up interview with the Director of Nursing (DON) on 10/21/2024 at 9:15 AM and conveyed to the DON that there was a Modification to the Discharge MDS dated [DATE] for Resident #133. The Director of Nursing (DON) acknowledged that the modification was completed at 7:11 am on 10/17/2024 by the LPN MDS Coordinator #23 for Section J1800 and J1900 related to a fall with injury. 48393 5) The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/24 at 11:32 AM, a review of Resident #118's clinical record revealed that a discharge MDS was completed on 7/14/2024. The resident was coded under MDS Section A2105 (Discharge Status) as discharged to short term general hospital. However, a review of progress notes on 10/08/24 at 11:48 AM revealed a discharge note dated 7/14/24 written by RN #11 at 2:08 PM which stated Resident #118 was discharged to a shelter. On 10/08/24 at 1:20 PM, the surveyor requested documents from the facility related to Resident #118's discharge status which included the Discharge MDS dated [DATE] Section A and the discharge progress note dated 7/14/24. On 10/17/24 at 3:32 PM, a subsequent review of Resident #118's clinical record was conducted. The review revealed that on 10/08/2024 at 2:43 PM, LPN MDS Coordinator #23 modified the existing record of the Discharge MDS dated [DATE] under Section A2105 (discharge status) to reflect that the resident was discharged home. On 10/17/24 at 4:37 PM, an interview was conducted with the VP of Clinical Services, Director of Nursing and Regional Risk Nurse #18 at which time the surveyor discussed the concerns regarding the identified MDS code inaccuracy and the record modification.

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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. 14894 Based on clinical record review and staff interview it was determined that the facility staff failed to ensure clinical records were maintained in an accurate manner. This was evident for 1 (#4) out of 44 residents in the survey sample. The findings include: The Activity Director (Staff #25) was interviewed on 10/7/24 at 9:22 AM. The team asked her where to find Activity logs documenting participation. She said they switched to putting Activities information into the computer. This surveyor requested Activity logs for Resident #4. Activity logs were brought to the survey team on 10/7/24 at 12:15 PM. This surveyor reviewed the activity logs on 10/7/24 at 12:45 PM and activity staff documented that the resident was participating in activities on 7/11/24, 7/15/24, 7/17/24, and 7/19/24. Further review of the clinical records revealed the resident was in the hospital from 7/10 to 7/22/24. This surveyor interviewed the Administrator and Regional Director of Clinical Services on 10/11/24 at 12:13 PM. The Surveyor showed them the activity logs. They confirmed that there are activities listed on the logs. They then acknowledged that staff documented providing activities while the resident was in the hospital.