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	10/09/2025

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on investigation of Intake #314680, observation, and interviews with facility staff it was determined the facility failed to provide an environment that promotes resident respect and dignity. This was evident for 1 (Resident #117) of 1 resident reviewed for dignity during the complaint survey. The findings include:On 10/08/2025 at 11:06 AM, during an interview with Geriatric Nursing Assistant (GNA) #12, when asked why so many residents were seen wearing hospital gowns, Staff #12 replied, they don't have clothes.On 10/08/2025 at 11:13 AM, during an observation of Resident #117, he/she ambulated down 100 hallway in a hospital gown. The gown was hanging off Resident #117's right shoulder, halfway down the arm, and exposing his/her back. On 10/08/2025 at 11:26 AM, during an interview with Registered Nurse (RN) Staff #14, stated that the Geriatric Nursing Assistant (GNA) needed to check the laundry for Resident #117's clothes. With the surveyor present, Staff #14 opened Resident #117's closet, which revealed only one sweatshirt. At that time, Staff #14 confirmed that Resident #117 had ambulated down the hallway with areas of his/her body exposed. On 10/09/2025 at 2:10 PM, during an interview with the Assistant Director of Nursing (ADON) Staff #21 stated that a resident that would have ambulated down the hallway in only a hospital gown, which exposed their shoulder and back, would be considered a dignity issue. At this time concern was shared with ADON.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on medical record review, and interviews it was determined that the facility failed to honor a resident's preference to receive a shower instead of a bed bath. This was evident for 1 (Resident #116) of 1 resident reviewed for preferences during the complaint survey.On 10/06/2025 at 9:40 AM, during an interview with Resident #116 stated, he/she has not had a shower in over 2 years, his/her preference is a shower, but has only received bed baths. Resident #116 continued to state, the shower room on the unit he/she resides on has not been in use and is used to store wheelchairs. On 10/06/2025 at 12:30 PM, during a review of Resident #116's medical record revealed the following: A Physician order dated 2/20/2023 weekly shower schedule on Wednesday and Saturdays on 7-3 shift.A Care plan with an initiated date of 07/29/2025 for maintenance that stated, Resident #116 is a long-term care or respite resident and requires assistance with their ADL's related to inability to perform ADLs independently, Parkinson's Disease. With an intervention that was initiated on the date of 07/29/2025, that indicated, Dependent for bathing. However, the care plan did not include the residents' preference to receive showers.Further review of Resident #116's medical record revealed a Documentation Survey Report v2 for September 2025 that indicated an Interventions/Task for ADL-Bathing/Showering. The report defined bathing types as: 1 for shower, 2 for tub bath, and 3 for bed/towel bath. Resident #117 had no documentation of receiving a shower (Type 1) Resident #116 was consistently documented as receiving only bed/towel baths (Type 3) throughout the month.On 10/07/2025 at 1:05 PM, during an interview the Director of Nursing (DON) stated if a resident's preference is a shower over a bed bath, the resident should receive a shower. The DON continued to state that the residents' care plan should reflect this preference, ensuring they receive a shower.On 10/09/2025 at 2:45 PM, the Assistant Director of Nursing (ADON) was made aware of the concern.

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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 observation during tours of the facility and investigations into intakes #314685 and #314689, it was determined that the facility staff failed to ensure the facility was free from odors. This was evident for 2 out of the 4 nursing units observed during the complaint survey. The findings include:This surveyor reviewed intakes #314685 and #314689 on 10/6/25 and 10/7/25. The first was from an anonymous complainant and the second one was from family members. Both alleged bad odors, especially the smell of urine, being very noticeable in the facility. This surveyor toured the facility on 10/6/25 at 8:10 AM and observed the smell of urine and a foul odor that was possibly body odor. This was evidence at the far end of the 300 unit. This surveyor toured the facility on 10/7/25 at 10:30 AM and observed the smell of urine and a foul odor, possibly body odor, at the far end of the 300 unit. This surveyor toured the facility on 10/8/25 at 7:50 AM and observed the smell of urine and a foul odor, possibly body odor, just past room [ROOM NUMBER] in the 300 unit. It was observed at 8:00 AM that the 500 unit had a foul odor halfway down the hall farthest from the nurses station. The surveyor shared the concern that the facility is not a clean and home-like environment was shared with the facility administration at the exit conference.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on investigation of intakes #314675 and #314688, review of facility documents, and interviews it was determined the facility failed to maintain an effective Grievance system. This was evident for 5 of 6 months of Grievance forms from the months of April through September of 2025 reviewed during the complaint survey. The findings include:On 10/06/2025 a review of intakes # 314675 and #314688 was completed, alleged by complainant's from Resident #101 and Resident #102. The Complainant for Resident # 101 alleged had 160. 00 worth of clothes missing. The Complainant for Resident #102 alleged that she called the facility to voice concerns and never received a call return. On 10/07/2025 at 2:57 PM, in review of Facility Grievance forms from the last 6 months (April through September of 2025), provided to the Surveyor by the Administrator revealed the following:Grievance forms were unavailable for four out of six months in 2025: April, June, July, and August. Continued review of the Grievance forms revealed, for the month of May of 2025 revealed 4 grievance forms with dates of 5/4/2025, 5/5/2025, 5/15/2025, and 5/29/2025 with documentation of the concern. However, these forms lacked information, including: the actions taken to investigate each grievance, a summary of the conclusion reached, the date of resolution, the corrective actions implemented, and how the disposition of each grievance was communicated to the Complainant. On 10/08/2025 at 9:23 AM, during an interview the Director of Nursing (DON) stated that the facility's grievance process addresses concerns as they arise. Staff or department heads document the concern on a Concern form, a copy of which is given to the Social Worker. The Social Worker then distributes the form to the appropriate department. Once a resolution is reached, it is communicated to the person who initially voiced the concern and documented on the same form. On 10/09/2025 at 9:20 AM, during an interview with the Administrator stated, Grievances are expected to be resolved within 7 days, with all details, including the investigation, resolution, and communication to the residents or family, documented on the grievance form. At this time, she verified that grievance concern forms for May 2025 were not fully documented. The Administrator stated that the facility only had forms for May and September and was unable to locate forms for the other four requested months. At this time the Administrator was informed of the concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, investigation of facility reports, and interviews, it was determined that the facility failed to conduct a thorough investigation of 1) and allegation of abuse and 2) an accident with a serious injury. This was evident for 2 (Residents #106, #114) of 25 residents reviewed during the complaint survey.The findings include:1) On 10/7/25 at 8:40 AM review of a facility report #2560996 had that Resident #106 fell at the facility and was sent out to the hospital, there s/he was found to have a rib fracture and pneumothorax (air in Lungs), a chest tube was placed to drain the air out. The resident told the hospital staff that they were pushed by an unknown person resulting in the fall with injury. The hospital staff made the facility aware of the abuse allegation. The resident was later discharged back to the facility on 7/10/25. When resident came back, the abuse allegation was investigated by the facility but was not substantiated. Further review of the investigative report did not produce documentation to show that witness statements or interviews with staff and other residents regarding the alleged abuse were obtained. In an Interview with the Director of Nursing (DON) on 10/7/25 at 8:45 AM, she was asked how she found out about the fracture, and she stated that she was told by the hospital staff that resident had a fracture and that resident stated he was pushed at the facility. So, when the resident came back, the facility conducted an abuse investigation. The DON was made aware of the missing documents and asked to provide the witness statements from the resident's nurse. She said that the nurse no longer works in the facility. She was asked to provide the witness statements, statements from other residents and staff who worked that day. On 10/07/25 at 9:35 AM, the DON stated that she could not find the missing documents. She explained that the former administrator and social work director handled the abuse investigation and that she called them to see if they can help locate the missing documents and is waiting for a call back. On 10/7/25 at 1:05 PM: The DON came back to say that she could not find any documentation related to other staff and resident's interviews or any witness statements, she was made aware that this was a concern because it indicated that a thorough investigation was not conducted. 2) The surveyor reviewed intake #314679 on 10/6/25 at 8:30 AM. According to the complainant, Resident #114 arrived at the dialysis center on 11/22/24 and complained of leg pain. Resident's leg was noted to be swollen. Resident #114 was asked what happened and the resident said they were dropped at the facility. The dialysis center nurse called the facility and informed them of the resident's complaint of pain and the swelling. Dialysis nurse said she documented the conversation with the facility nurse, the vital signs, and signed her name on the flow sheet. The dialysis nurse alleged that when the resident returned on Monday the communication flow sheet that was sent to the facility on Friday no longer had the dialysis nurse's written notes. This surveyor reviewed the clinical record for Resident #114 on 10/6/25 at 9:00 AM. It revealed that an incident report was completed by the facility on 11/22/24 at 3:47 PM. Resident stated while being transported by the driver, they were not strapped in, and the driver made a sharp turn, and they hit their left leg. Resident was administered Tylenol 60 mg, and the nurse practitioner (CRNP) was notified. The CRNP ordered a Doppler to rule out a Deep Vein Thrombosis (DVT -- blood clot in a deep vein) and X-rays to rule out a fracture(s). Edema was noted on left leg but no redness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The X-ray was obtained on 11/22/24. It showed an acute mildly displaced fracture of the femur but negative for fractures to the foot and ankle. CRNP was notified. Pain medication was ordered and administered. The Doppler was obtained on 11/25/24. The Doppler was negative for DVT. The primary physician wrote a progress note on 11/26/24 at 5:22 PM. The patient is awake and alert, resting in bed. The patient is complaining of some pain in the left knee and is otherwise unable to give a good history of why it hurts. Resident is not a good historian. On Friday, the patient was noted to have swelling and pain in [his/her] left lower extremity and foot. As a result, the on-call provider had ordered Xray for [his/her] legs. The results were significant for a new acute left mildly displaced femur fracture. The patient has been so far managed with immobilization and acre [Ace] wrap to the area and is pending an orthopedics appointment next week. It is unclear how the patient exactly got the fracture, but there was a report from nursing that [resident] hit their leg in the car during transfer to [his/her] appointment. Given [his/her] long history of advanced osteoporosis, the patient is at an elevated risk for repeated fractures, and it is not to be unexpected. The resident is sent to the hospital via 911 on 11/27/24 at 2:38 PM. A nurse called John Hopkins Bayview ER on [DATE] at 6:32 PM regarding resident's status. The ER nurse informed the nurse that resident is going to be admitted for further evaluation. Resident's son was made aware. The surveyor interviewed the complainant on 10/7/25 at 9:17 AM. She said she was told by dialysis nurse that resident stated they fell on Friday, but the facility told the dialysis center nurse that the resident hit leg during transport. Dialysis center nurse said the driver did not report any incident and they (the dialysis center) trust him. This surveyor interviewed the Director of Nursing (DON) on 10/07/25 at 1:50 PM. She said the resident did not have a fall. Injury was the result of hitting his/her leg on the bus on the way to the Dialysis center. DON said resident had osteoporosis and had a fracture of the same leg that occurred sometime in June. DON said the previous Administrator may have investigated it and may have called the dialysis center, but they have no record because the previous Administrator may have taken the investigation with him. This surveyor requested the dialysis communication logs for this resident on 10/8/25 at 10:20 AM from medical records. The Administrator informed this surveyor on 10/9/25 at 12:30 PM that she looked for the dialysis communication book and all she could find were the communication flow sheets from September to November 2024. A review of the dialysis communication flow sheets revealed that the one for 11/22/24 was not signed by the dialysis nurse and the note the nurse wrote was gone. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This surveyor interviewed Staff #24 on 10/9/25 at 12:54 PM. He was asked what happened to this resident. He replied that it was his understanding that when the resident was being transported to the Dialysis center the van took a sharp turn and the resident hit their leg on the side of the van. This was witnessed by the escort. He said when the resident got to the facility, he/she complained of pain. Responsible Party was notified. The resident was treated upon return. X-ray was obtained. He asked if there was anything else that I needed. This surveyor showed him the communication flow sheets for dialysis. This surveyor mentioned that the Dialysis center sent a write up of events via the communication flow sheets. He said he did not see it. This surveyor said that was the survey team's concern as well. When the communication flow sheet for 11/24/25 came back it was blank. He said, Well, they would be blank because the sheet they sent would stay here in the facility. A review of all the information the facility had for this incident revealed that there were no statements from the van driver, escort, resident, facility nurse, and/or the geriatric nursing assistants that were assigned to the resident in the 24-hour period prior to the resident complaining of leg pain.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on complaint #2596795, record reviews, and interviews, it was determined that the facility failed to develop an impaired mobility care plan as required. This deficiency was observed in 1 (Resident #108) of 4 care plans reviewed for mobility needs during the complaint survey.The findings included:A care plan serves as a crucial tool to summarize a resident's healthcare needs, treatments, and care goals.On 10/9/2025, a review of complaint #2596795 alleged that the facility did not have operational Hoyer lifts in August 2025. The surveyor subsequently requested a list of Hoyer lift-dependent residents, selected and examined 4 residents' charts (#108, #123, #124 and #125) including their respective care plans.On 10/9/2025 at approximately 1:00 pm, a review of Resident #108's medical records indicated a history of left-sided paralysis and left-sided weakness. The resident's care plan also revealed dependence for activity of daily living (ADL) including mobility or transfer needs; however, there was no documented evidence to support the facility's development of a resident-specific care plan addressing Resident #108's mobility care needs and the interventions implemented to assist with mobility.On 10/9/2025, at approximately 2:00 pm, during an interview with the Assistant Director of Nursing (ADON), the surveyor inquired about the process for developing a resident care plan. The ADON explained that care plan development is completed by an interdisciplinary team, with each department responsible for developing the care plan to reflect the treatment provided. The ADON was presented with a scenario involving a resident with mobility concerns and she was asked to explain how the care plan would address the care needs. She explained that the care plan should address the resident's mobility needs by specifying the mode of transfer (e.g., wheelchair or Hoyer lift dependent) and the required number of staff for transfers.The surveyor then requested that the ADON reviewed Resident #108's care plan to assess the adequacy of the facility's care plan development in addressing the resident's mobility. Following a thorough review of the resident's care plan, the ADON acknowledged that it did not adequately address the resident's mobility needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on investigation of intakes, record review, observation, and interview, it was determined that the facility failed to 1) provide incontinence care timely, 2) provide showers for dependent residents, and 3) provide incontinence care in a professional manner. This as evidence for 4 residents (Residents #119, #105, #121, #112) out of 25 residents reviewed during the complaint survey.The findings include: 1) Intakes #314680, #314688, and #314675 were reviewed on [DATE] and [DATE]. All 3 intakes had alleged an extended wait time to receive incontinence care. On [DATE] at 11:40 AM, during an observation, the surveyor overheard Resident #119's complainant inform Geriatric Nursing Assistant (GNA) Staff #7 that Resident #119 needed to be changed and had been waiting 30 minutes. Staff #7 responded she would return or find someone. On [DATE] at 11:42 AM, during an interview with the complainant for Resident #119, stated he/she arrived at the facility at 11:00 AM. At that time a therapist (Staff #8) brought Resident #119 to the room from therapy, noting Resident #119 needed to be changed. The complainant further explained Resident #119 had a bowel movement and had been waiting since Resident #119 returned from therapy. On [DATE] at 11:57 AM, during a continued observation, Staff #7 (GNA) entered Resident #119's room to provide incontinent care. This resulted in Resident #119 experiencing a 57-minute delay for incontinence care following a bowel movement. On [DATE] at 12:05 PM, during an interview with Staff #7 (GNA) reported she was informed by an unnamed GNA and therapist upon return from a break that Resident #119 required incontinence care. Staff #7 stated that other staff members should provide coverage during breaks and noted everyday there are residents' concerns about extended waiting times for incontinence care. On [DATE] at 12:27 PM, during an interview with Physical Therapist Assistant (PTA) Staff #8 reported returning Resident #119 to the unit at 11:00 AM for incontinence care. Resident #119's complainant was present during this time. Staff #8 (PTA) further stated that an unnamed GNA at the nurses' station was informed of Resident #119's need for incontinence care. On [DATE] at 1:05 PM, during an interview, the Director of Nursing (DON) stated incontinence care must be provided upon staff awareness. Regardless of staff assignment, if a staff member is on break, another staff member would provide coverage of the care needed related to incontinence. On [DATE] at 2:45 PM, the Facility's Assistant Director (ADON) was made aware of the concern. 2) On [DATE] at 10:05 AM, review of a complaint intake #314683 alleged that Resident #105 was not bathed during their first 3 days in the facility. Review of the medical records showed that this resident was admitted on [DATE] to the facility, was only there for a week before s/he expired. Review of the physician's order showed that their shower days were scheduled 2x a week on Wednesdays and Saturdays. Further review of their Kardex did not show that the resident was given a shower on [DATE], which was their next scheduled day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:10 AM the facility was asked for a copy of another dependent resident's (Resident #121) Kardex, a tool utilized by the geriatrics nursing assistants (GNA) to document when showers are given and other daily care schedules. Resident #121 is dependent on the facility staff to provide showers twice a week. Review of their [DATE] Kardex showed that Resident #121 was showered only once for the entire month, there was no documentation to indication that the resident refused to be showered. In an Interviews with Staff #7 a Geriatric Nursing Assistant (GNA) on [DATE] at 11:40 AM, she was asked how often the residents are given showers and she said about 2-3 times a week. She was asked how many shower rooms they have in their unit, and she said two. She was asked if the shower rooms were functional and she said no. She explained that they have 2 shower rooms but only use one shower room with one stall because the other shower room was currently out of order for over 3 months. On [DATE] at 11:06 AM Staff #12 a GNA was asked again about their shower rooms, and she stated that one shower room has not been in use since she started working there, which was about 6 months ago. Staff #10, a maintenance director also confirmed in an interview on [DATE] that the shower room on the 500 Unit has been down for 6-9 months because it was leaking water underneath the floor to the gym. He said the shower room needed remodeling, that the only shower working has one stall and is located on the 100 Units. He confirmed that the total number of working showers for the entire facility was 4 for 130 residents. On [DATE] at 11:20 AM, The Director of nursing was made aware of the concern, she stated she will follow up. 3) The surveyor interviewed a family member of Resident #112 on [DATE] at 1:17 PM. Family member said that on the last night the resident was in the facility the resident had an episode of incontinence. The Geriatric Nursing Assistant (GNA) who transferred the resident out of the bed to a wheelchair so the bed linen could be changed, moved the resident out into the hallway. The resident was in the hallway from 4 AM to 12 Noon. This surveyor interviewed someone who requested to remain anonymous on [DATE] at 2:15 PM. This person said the resident would call out all night asking for help. This person said that on the last night the GNA got the resident out of bed to change the sheets and then left [him/her] in the hallway for the next 4-5 hours. The facility was informed of the findings at the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on complaint intakes, observations, and staff interviews, it was determined that the facility failed to provide quality of care services to their residents by not having clean towels or wash clothes used for washing up. This was evident for 3 (#314683, #314678 and #314685) of 5 complaint intakes reviewed during a complaint survey.The findings include:On 1/7/25 at 10:14 AM review of incident #314683 alleged that Resident #105 was frequently left in their soiled adult briefs for extended periods, sometimes for over two hours. During their first three days at the facility, the resident was left in bed without being bathed. When family members attempted to clean the resident, they were informed there were no clean towels or wash-clothes available. They had to go to a local store to purchase these items to care for the resident themselves.Review of intake #314678 also alleged that the facility never had wipes, towels and wash clothes for the residents and were always running out hindering staff from doing their jobs. When aides tell the facility there's no linen, they suggest cutting a towel to make a washcloth or using bed sheets and pillowcases. Those residents are left soaked from their clothes to their beds because of this.Further review of intake #314685 alleged that the facility does not have appropriate materials for caring for the clients, they do not have soap and hygiene material for some of the clients. There was nothing to provide oral care with and they had to use a Pillowcase because there was no washcloth available to wash the Clients.On 1/7/25 at 11:30 AM and 11:35AM, observation of the linen cart on the 300 and 100 Units revealed a cart with no wash clothes, few towels and linens.On 1/7/25 at 11:40 AM in an Interview with Staff #7 a Geriatric Nursing Assistant (GNA). The GNA was asked if the facility had enough wash clothes and they said that the facility does not have enough linen for the residents, especially wash clothes. Staff #7 stated that this happens frequently, that most of the time, the aides have to go down to the laundry room to search for linens. When they get there, the laundry aides are still washing the linens, and they are forced to wait till it's done before they can get any. She was asked the reason for the shortage, and she said the facility doesn't have enough linen to provide care to residents or maybe enough laundry staff to do a quick turnaround. She was asked how that affects residents' care, and she said that residents don't get their baths done, care is not provided timely, and residents don't get the care they deserve. She was asked if the management are aware of the shortage and she said that they had a meeting with the new administrator and were told the issue would be resolved.In another interview with Staff #17 a laundry aid on 10/7/25 at 11:50 AM, She was asked about wash-clothes and she said they don't have any in the building because the aides hide them in the residents' closets or throw them out. She said they do a sweep once a week going from one resident's closet to another to recover linens from where the staff stash them. She said she only had 15 wash clothes to put out that morning for the entire building. That the aides throw linens away in the trash when heavily soiled. She said the linen recycling process is a mess and the residents suffer from it, that there are no washcloths on storage currently.On 10/7/25 at 12 :45 PM in a Joint interview with Staff #15 the Environmental Services Director (EVS) and the Administrator, they were made aware of the numerous complaints regarding linen shortages from residents, staff and families and were asked how that is being resolved. Staff #15 said it's her daily struggle and that staff stash them in the residents' closet or throw them away in the trash when soiled. She sweeps the residents' room frequently to recover stashed linens, but the aides stash them back. The administrator said she just put in new orders for more linens and has designated a section so each shift can have their own linen. They were made aware that this was still a concern because the issue has not been resolved and is affecting resident care.

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	10/09/2025

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

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

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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 clinical record review and an investigation of intake #314682 it was determined that the facility staff failed to conduct a thorough investigation into an accident thereby denying facility staff the ability to adequately evaluate possible cause(s) to this and future accidents. This was evident for 1 (Resident #113) out of 1 resident reviewed for accidents during the complaint survey.The findings include:A review of Resident #113's clinical record was conducted on 10/7/25 at 10:00 AM as well as the review of the allegations made in intake #314682. It was revealed that on 2/23/25 the resident was found on the floor of the resident's room. Nursing staff observed that the resident had a hematoma (localized collection of blood the pools similar to a bruise) and a laceration over the left eyebrow as well as a large amount of bleeding. Staff assisted the resident to bed, applied ice to the hematoma, and a pressure dressing was applied over the left eyebrow to control the bleeding. 911 was called and the resident was sent to the hospital. Further review of the clinical record on 10/7/25 revealed the resident had a diagnosis of severe intellectual disabilities. This surveyor requested the facility fall investigation on 10/7/25. An assessment of the incident was provided but there were no interviews of staff or of the roommate. The staff assessment of the incident included noting the resident to be alert with periods of forgetfulness, impaired memory, and gait imbalance. Resident stated, I got up and walked to bathroom and fell hitting my head on the floor. Staff concluded that a predisposing situational factor was ambulating without assistance. The facility administrative team was informed of the lack of interviews which could have provided information as to the root cause of the incident and/or other information that may be used to prevent further incidents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation of a test tray and information provided from intakes, it was determined that the facility staff failed to ensure food was served in a palatable manner. This was evident for 1 out of 2 test trays sampled.The findings include:A test tray was provided to the survey team on 10/9/25 at 8:30 AM. The scrambled eggs and the bacon tested at a palatable level. The cream cheese was 53.9 F, the milk was 52.8 F, the apple juice was 49.6 F. All three were above the 41-degree limit for cold food. The survey team informed the facility administrative team at the exit conference.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on investigation of intake #314675, observation, and interview it was determined the facility failed to properly verify pertinent information prior to meal service. This was evident for 1 (Resident #118) of 1 reviewed for meal service during the complaint survey.The findings include:On 10/08/2025 at 1:12 PM, during an observation and interview of meal service on 300 Hall, the surveyor requested the test tray (a sample meal requested by surveyors to evaluate the quality and temperature of the food served to residents) from the 300-meal cart. Geriatric Nursing Assistant (GNA) Staff #18 confirmed she had served the test tray to Resident #118. Upon entering Resident #118's room, the surveyor, with GNA Staff #18 present, observed that the meal tray lacked a meal ticket. GNA Staff #18 acknowledged the absence of a meal ticket (a slip containing information that contains the resident's name, room number, diet type, food texture, liquid consistency, and allergies) and admitted that she should not have served the meal without verifying the information. On 10/08/2025 at 1:40 PM, during an interview with Licensed Practical Nurse (LPN) Staff #19, stated if a meal ticket is not on a meal tray, the meal tray would be returned to the kitchen. On 10/08/2025 at 2:00 PM, during an interview with the Director of Nursing (DON), stated Staff are to verify meal tickets against resident name and information that includes tray contents, diet, room number, texture of food, and liquid consistency. Meal trays without a corresponding ticket should not be served. At this time the Director of Nursing (DON) was made aware of the concern.

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, investigation of intake #314679, staff interview, and interview with complainant, it was determined that the facility staff failed to ensure medical records were complete with all communication flow sheets with the dialysis center. This was evident for 1 (Resident #114) resident out of 25 residents that were part of the survey sample.The findings include: The surveyor reviewed intake #314679 on 10/6/25 at 8:30 AM. According to the complainant, Resident #114 arrived at the dialysis center on 11/22/24 and complained of leg pain. The Resident's leg was noted to be swollen. Resident #114 was asked what happened and the resident said they were dropped at the facility. The dialysis center nurse called the facility and informed them of the resident's complaint of pain and the swelling. Dialysis nurse said she documented the conversation with the facility nurse, the vital signs, and signed her name on the flow sheet. The dialysis nurse alleged that when the resident returned on Monday, the communication flow sheet that was sent to the facility on Friday no longer had the dialysis nurse's written notes. This surveyor reviewed the clinical record for Resident #114 on 10/6/25 at 9:00 AM. It revealed that an incident report was completed by the facility on 11/22/24 at 3:47 PM. The Resident stated while being transported by the driver, they were not strapped in, and the driver made a sharp turn, and they hit their left leg. Resident was administered Tylenol 60 mg, and the nurse practitioner (CRNP) was notified. The CRNP ordered a Doppler to rule out a Deep Vein Thrombosis (DVT -- blood clot in a deep vein) and X-rays to rule out a fracture(s). Edema was noted on left leg but no redness.The X-ray was obtained on 11/22/24. It showed an acute mildly displaced fracture of the femur but negative for fractures to the foot and ankle. CRNP was notified. Pain medication was ordered and administered.The Doppler was obtained on 11/25/24. The Doppler was negative for a DVT. The primary physician wrote a progress note on 11/26/24 at 5:22 PM. The patient is awake and alert, resting in bed. The patient is complaining of some pain in the left knee and is otherwise unable to give a good history of why it hurts. Resident is not a good historian. On Friday, the patient was noted to have swelling and pain in [his/her] left lower extremity and foot. As a result, the on-call provider had ordered Xray for [his/her] legs. The results were significant for a new acute left mildly displaced femur fracture. The patient has been so far managed with immobilization and acre [Ace] wrap to the area and is pending an orthopedics appointment next week. It is unclear how the patient exactly got the fracture, but there was a report from nursing that [resident] hit leg in the car during transfer to [his/her] appointment. Given [his/her] long history of advanced osteoporosis, the patient is at an elevated risk for repeated fractures, and it is not to be unexpected.The resident was sent to the hospital via 911 on 11/27/24 at 2:38 PM. A nurse called [name of hospital]'s emergency room (ER) on 1/27/24 at 6:32 PM regarding resident's status. The ER nurse informed the facility nurse that resident is going to be admitted for further evaluation. Resident's responsible party was made aware.This surveyor interviewed complainant on 10/7/25 at 9:17 AM. She said she was told by dialysis nurse that resident stated they fell on Friday, but the facility told the dialysis center nurse that the resident hit leg during transport. Dialysis center nurse said the driver did not report any incident and they (dialysis center) trust him. This surveyor interviewed the Director of Nursing (DON) on 10/07/25 at 1:50 PM. She said the resident did not have a fall. Injury was the result of hitting his/her leg on the bus on the way to the dialysis center. DON said resident had osteoporosis and had a fracture of the same leg that occurred sometime in June. DON said the previous Administrator may have investigated it and may have called the dialysis center, but they have no record because the previous Administrator may have taken the investigation with him.This surveyor requested the dialysis communication logs for this resident on 10/8/25 at 10:20 AM from medical records.The Administrator informed this surveyor on 10/9/25 at 12:30 PM that she looked for the dialysis communication book and all she could find were the communication flow sheets from September to November 2024. A review of the dialysis communication flow sheets revealed that the one for 11/22/24 was not signed by the dialysis nurse and the note the nurse wrote was gone. This surveyor interviewed Staff #24 on 10/9/25 at 12:54 PM. He was asked what happened to this resident. He replied that it was his understanding that when the resident was being transported to the Dialysis center the van took a sharp turn and the resident hit their leg on the side of the van. This was witnessed by the escort. He said when the resident got to the facility, he/she complained of pain. Responsible Party was notified. The resident was treated upon return. X-ray was obtained. He asked if there was anything else that I needed. This surveyor showed him the communication flow sheets for dialysis. This surveyor mentioned that the Dialysis center sent a write up of events via the communication flow sheets. He said he did not see it. This surveyor said that was the survey team's concern