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Form Approved OMB
No. 0938-0391

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	02/04/2026

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff interview, it was determined the facility failed to post a notice of where the results of the most recent surveys, certifications, and complaint investigations were located. This was evident during the first day of the complaint survey.The findings include:On 2/3/26 at 9:26 AM the surveyor asked the receptionist where the survey book was located as there were no signs anywhere in the lobby that indicated where the survey book was. The receptionist informed the surveyor that the book was in the drawer of the black table that was located across the lobby outside of the Nursing Home Administrator's office. There were plants on top of the table and there were 2 drawers. There was no sign on or near the table, on the wall, or anywhere in the lobby that would have directed residents or visitors as to where the survey book was located.On 2/3/26 at 12:50 PM a survey sign was located on a wall in the nursing unit, however the sign stated, state survey book located in the front lobby. The sign did not say the book was in a drawer. On 2/3/26 at 1:23 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated that she kept the survey binder in the drawer because there was a resident that would tear the book apart. The Regional Director of Clinical Operations came out to the lobby and stated they usually had a sign posted, but he could not find the sign. He asked the receptionist who did not know where the sign was located.

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 - 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 of Resident # 1 room [ROOM NUMBER] B, the facility failed to clean the room, sweep and mop the floor. This was evident for 1 out of 1 resident and room. Findings include:On 2/3/26 at approx. 10:15 AM this surveyor went into room [ROOM NUMBER] B where Resident # 1 resides. When this surveyor entered the room, trash was all over the floor such as wrappers, Kleenex, hair brush and food. Left over food and crumbs were all over the bedside table for Resident #1 and his roommate. There was also stuck on food on the cushion that was in the wheelchair. The floor mat was dirty and the corners in the room were dusty and dirty as well. This surveyor showed this to the Charge Nurse staff # 7 and the Director of Nursing (DON) staff # 2. Staff # 7 stated that Resident # 1 is a messy eater and gets food everywhere. This may be true, but the roommate's side of the bedroom was just as dirty. The Administrator was made aware.

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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. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#3, #6, #7, #8) of 4 residents reviewed for falls during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.1) On 2/3/26 at 10:09 AM a review of Resident #3's medical record was conducted and revealed Resident #3 had a fall on 10/14/25. Resident #3 was noted with a 1 cm. by 0.1 cm. laceration that was bleeding. Resident #3 was sent to the emergency room and had 2 staples placed in the scalp of the head.Further review of Resident #3's medical record revealed Resident #3 had a fall on 9/19/25 with no injuries observed.Review of Resident #3's annual MDS with an assessment reference date (ARD) of 11/20/25, Section J, falls, only captured 1 fall without injury. The facility failed to capture the 10/14/25 fall with injury.On 2/4/26 at 9:40 AM an interview was conducted with the MDS Coordinator Staff #17. Staff #17 confirmed the error.2) On 2/3/26 at 2:00 PM a review of Resident #6's medical record was conducted and revealed Resident #6 had a fall on 9/4/25. A 9/4/25 change in condition note documented Resident #6 was observed sitting on the floor to the left side of the bed. There were no injuries noted.A second change in condition note dated 10/14/25 documented that Resident #6 was observed lying on the floor to the left side of the bed. There were no apparent injuries.Review of the MDS with an ARD of 11/21/25, Section J 1900, captured 1 fall with no injury. The facility failed to capture the second fall.On 2/4/26 at 9:40 AM an interview was conducted with the MDS Coordinator Staff #17. Staff #17 confirmed the error.3) On 2/3/26 at 2:15 PM a review of Resident #7's medical record was conducted and revealed Resident #7 had a fall on 10/3/25. A 10/3/25 change in condition note documented Resident #7 was found kneeling on the floor. Resident #7 told the nurse that he/she was trying to transfer from the bed to the wheelchair. Resident #7 was assessed and no injury was noted from the fall.Review of the MDS with an ARD of 11/18/25, Section J 1900, documented no falls. The facility capture the fall on 10/3/25.On 2/4/26 at 9:40 AM an interview was conducted with the MDS Coordinator Staff #17. Staff #17 confirmed the error.4) On 2/3/26 at 2:25 PM a review of Resident #8's medical record was conducted and revealed Resident #8 had a fall on 10/22/25. A 10/22/25 nursing note documented that Resident #8 had a fall that was reported by the housekeeper to the nurse. The resident was standing at the end of the bed, started coughing and sat on the floor. No injuries were noted.Review of the MDS with an ARD of 1/6/26, Section J 1900, documented no falls. The facility failed to capture the fall on 10/22/25.On 2/4/26 at 9:40 AM an interview was conducted with the MDS Coordinator Staff #17. Staff #17 confirmed the error.On 2/4/26 at 1:19 PM the Nursing Home Administrator was informed of the concern.

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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 medical record review and interview, the facility staff failed to provide treatment/services as ordered to prevent/heal pressures ulcers (Resident #5). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey.The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). Review of Resident #5's medical record on 2/3/26 revealed the Resident was admitted to the facility in 2024 with a diagnosis to include adult failure to thrive. Failure to thrive (FTT) in adults, particularly the elderly, is a syndrome marked by unintentional weight loss, decreased appetite, poor nutrition, and physical inactivity. Further review of Resident #5's medical record revealed a 3/18/25 Skin Observation Weekly note that stated the Resident skin observation was completed and a new skin condition noted that was 4 cm length by 1 cm width, pink in color, no drainage noted, cleansed with wound cleanser and dressing applied. Further review of Resident #5's medical record revealed the Resident was seen by the Wound Doctor on 3/20/25. At that time the Wound Doctor assessed the Resident as having a Stage III wound of the left buttock and ordered the Resident to have Calcium Alginate dressing daily. Further review of Resident #5's medical record revealed the Resident was seen by the Wound Doctor on 3/27/25 and discontinued the Calcium Alginate dressing and ordered zinc ointment every shift. Review of Resident #5's March 2025 Treatment Administration Record revealed the facility staff failed to change the Resident's left buttock wound dressing from wound cleanser to Calcium Alginate from 3/20/25 until 3/27/25. Interview with the Regional Director of Clinical Operations on 2/4/26 at 11:10 AM confirmed the Surveyor's findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview, it was determined the facility staff failed to implement the Dietitian's recommendations for residents with weight loss (Resident #5 and #10) and failed to follow up on a physician's report for a resident evaluated for weight loss (Resident #5). This was evident for 2 of 3 residents reviewed for weight loss during a complaint survey. The findings include:1.Review of Resident #5's medical record on 2/3/26 revealed the Resident was admitted to the facility in 2024 with a diagnosis to include adult failure to thrive. Failure to thrive (FTT) in adults, particularly the elderly, is a syndrome marked by unintentional weight loss, decreased appetite, poor nutrition, and physical inactivity. Further review of Resident #5's medical record revealed the Resident was assessed by the Dietitian on 4/10/25 for nutritional follow up. The Dietitian documented that the Resident continues to experience weight loss despite supplementation and assistance during meals. His/her diagnoses of dementia, adult failure to thrive, mild protein-calorie malnutrition, and comorbid conditions may be hindering progress toward nutritional goals. This was discussed with the medical team during IDT (Interdisciplinary Team) meeting. A GI (gastrointestinal) consult has been ordered due to ongoing weight loss and a history of being underweight. Review of Resident #5's physician orders revealed the Resident was scheduled for a GI consult related to weight loss Telehealth on 4/29/25. Review of Resident's electronic and paper medical records revealed no notes from the GI consult. Interview with the Acting Director of Nursing on 2/4/26 at 11:20 AM confirmed the facility staff did not have the results of the GI consult on 4/29/25. The facility's failed to obtain the results of the GI consult and therefore unable to determine if there were any recommendations for Resident #5's weight loss. Further review of Resident's medical record revealed the Resident was assessed by the Dietitian on 5/6/25 for weight loss/high risk follow up. The Dietitian documented Weight monitoring per MD order weekly times 4. Review of Resident #5's documented weights revealed the facility staff failed to obtain a weekly weight on 5/21/25. Interview with the Regional Director of Clinical Operations on 2/4/26 at 11:20 AM confirmed the Surveyor's findings. 2.Review of Resident #10's medical record on 2/4/26 revealed the Resident was admitted to the facility in 2025 with a diagnosis to include malnutrition. Further review of Resident #10's medical record revealed the Resident was assessed by the Dietitian on 1/8/26 for weight loss. At the time the Dietitian recommended weekly weights times 4. The facility staff weighed the Resident on 1/13 and 1/18/26 but have not weighed the Resident since 1/18/26. The Dietitian has not seen the Resident again since 1/8/26.Interview with Regional Director of Clinical Operations on 2/4/26 at 12:45 PM confirmed the facility staff failed to obtain weekly weights times 2 weeks for Resident #10 per the Dietitian's recommendations.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on medical record review and interview, it was determined the facility staff failed to obtain a diagnostic test as ordered for a resident (Resident #5). This was evident for 1 of 11 residents reviewed during a complaint survey. The findings include:Review of Resident #5's medical record on 2/3/26 revealed the Resident was admitted to the facility in 2024 with a diagnosis to include goiter. Goiter is an enlargement of the thyroid gland.Further review of Resident #5's medical record revealed the Resident had a chest X-ray completed on 3/3/25 to rule out pneumonia. Review of the X-ray results revealed it stated: a nonspecific superior mediastinal widening. Overall findings are worse compared to 4/22/2024. CT recommended. A CT (computed tomography) scan is a quick, painless, and non-invasive medical imaging test using X-rays to create detailed 3D, cross-sectional slices of bones, blood vessels and soft tissues. Review of Resident #5's physician orders revealed the order for the CT scan was not placed until 3/28/25. The 3/28/25 ordered was updated on 4/3/25 to include a scheduled date for the CT scan on 4/8/25. On 4/7/25 the CT scan order was discontinued due to imaging not taking resident on stretcher.Further review of Resident #5's medical record revealed the Resident was hospitalized from 4/15 until 4/18/25. Review of the 4/18/25's hospital discharge summary revealed it stated: On admission imaging noted Moderate left paratracheal soft tissue density deviating the trachea to the right, compatible with probable substernal thyroid. Recommend correlation with chest CT. outpatient.Further review of Resident #5's medical record revealed the chest CT was not ordered or obtained until the Resident was sent to the hospital on 6/9/25. Interview with the Regional Director of Clinical Operations on 2/4/26 at 11:10 AM confirmed the facility staff failed to follow up and obtain a CT for Resident #5 from 3/3/25 until 6/9/25.