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

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 - 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 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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 - Some	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. On 10/2/24 at 10:00 AM observation of room [ROOM NUMBER] revealed the floor around bed B was still sticky.

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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on staff interviews and medical record review it was determined that the facility failed to provide notification to the Ombudsman of Residents that transferred to the hospital and discharged from the facility. This was found to be evident in 9 out of 9 Residents (#4, #8, #24, #32, #33, #41, #60, #105 and #118) reviewed for hospitalization s. The findings include: 1. During an interview with Resident #8 on 10/01/2024 at 08:57 AM, the Resident stated to the surveyor that he/she was hospitalized at Greater Baltimore Medical Center in April of this year. The surveyor reviewed Resident #8's medical record on 10/7/24 at 08:10 AM and the medical record review revealed that Resident #8 was hospitalized on [DATE]. The surveyor interviewed the Nursing Home Administrator (NHA) at 01:13 PM on 10/7/2024 and requested documentation of notification to the Ombudsman when a Resident is transferred to the hospital. The NHA stated that notification to the Ombudsman has not been completed up until a few months ago. The surveyor requested this documentation from the Nursing Home Administrator (NHA). The surveyor interviewed Resident #33 on 10/1/2024 at 09:58 AM. Resident #33 stated to the surveyor that he/she had been in the hospital for a fall. A medical record review was conducted by the surveyor on 10/8/2024 at 10:20 AM and that review revealed that Resident #33 had been hospitalized [DATE], 7/27/2024 and 9/6/2024. Further review of the medical record on 10/8/2024 revealed that there was no notification of documentation that the Ombudsman was notified of these transfers of Resident #33 to the hospital. During an interview with Resident #41 on 10/1/2024 at 10:25 AM the Resident stated that he/she was hospitalized for a fall. The surveyor conducted a chart review on 10/1/2024 at 08:30 AM and the chart review revealed that Resident #41 was hospitalized on [DATE], 8/5/2024 and 9/9/2024. Further review of Resident #41's medical record revealed that there was no notification that the facility had notified the Ombudsman of the transfers to the hospital for Resident #41. At 7:58 AM on 10/8/2024 the surveyor reviewed a binder of documentation received from the Nursing Home Administrator (NHA) for Ombudsman notification of transfers from August 2024 to October 2024. This documentation in the binder included individual emails from the facility Social Services Director to the Ombudsman for Resident discharges and transfers for the months of August 2024 to October of 2024. In addition, there was an Admission/Discharge To/From Report from the facility computer documentation system for 8/1/2024 to 9/30/2024 with a time stamp of 10/7/2024 at 14:08 PM. (continued on next page)

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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview with the Nursing Home Administrator (NHA) at 9:05 AM on 10/8/2024 the surveyor confirmed with the NHA that this was the complete documentation of facility notification to the Ombudsman. The surveyor conveyed to the NHA that there was no documentation that the Ombudsman was notified of Resident #8, #33 and #41 transfers to the hospital. 14894 2. A review of Resident #4's clinical record on 9/30/24 revealed the resident was in the hospital from 7/10/24 to 7/22/24. Further review revealed that the Ombudsman was not notified. A review of Resident #24's clinical record on 9/30/24 revealed the resident was in the hospital from 7/29/24 to 8/2/24. Further review revealed that the Ombudsman was not notified. A review of Resident #105's clinical record on 9/30/24 revealed the resident was in the hospital 8/17 to 8/19/24 and 9/19 to 9/20/24. The Ombudsman was not informed about either trip to the hospital. 10/07/24 at 01:20 PM the Administrator was interviewed on 10/7/24 at 1:20 PM. He stated that they have not been telling the Ombudsman of the Centers for Medicare/Medicaid Services (CMS) requirement that the Ombudsman be notified monthly. 48393 3. On 10/08/24 at 09:39 AM, a review of Resident #60's clinical record revealed that Resident #60 was transferred to the hospital for further evaluation of his/her medical needs on the following dates: 12/16/23, 1/18/24, 2/16/24, and 3/12/24. Further review of Resident #60's clinical record revealed no documentation that the local ombudsman was notified of the hospital transfers in writing. On 10/08/24 at 12:35 PM, an interview conducted with the Nursing Home Administrator (NHA) revealed that the facility just started sending transfer and discharge notices to the Ombudsman a few months ago via email. The NHA further stated that transfer notices were not provided to the Ombudsman for Resident #60's hospital transfers on 12/16/23, 1/18/24, 2/16/24, and 3/12/24. On 10/08/24 at 11:53 AM, a review of Resident #118's clinical record revealed that Resident #118 was discharged from the facility on 7/14/2024. Further review of Resident #118's clinical record revealed no documentation that the local ombudsman was notified of the resident's discharge in writing. On 10/08/24 at 12:35 PM, an interview conducted with the NHA revealed that the facility just started sending transfer and discharge notices to the Ombudsman a few months ago via email. The NHA further stated that a discharge notice was not provided to the Ombudsman for Resident #118's discharge on 07/14/2024. 50504 4. On 10/1/24 at 02:36 PM a review of the clinical record for Resident #32 revealed that the resident was transferred to the hospital on 11/1/23 for Hypoxia and returned to the facility on [DATE]. (continued on next page)

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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no evidence in the clinical record to show that the facility staff provided written notification to the Ombudsman for Resident #32's transfer to the hospital On 10/4/24 at 11:37AM the Director of Nursing and the Regional Director of Clinical Operations were interviewed by the surveyor and made aware of the findings. No evidence of the notification to the Ombudsman was provided to the team prior to the survey exit.

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

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 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)

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

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 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)

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

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 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.

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on medical record review, and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reveal accurate interventions to meet the needs of the residents. This was evident for 2 (Residents #32 and #91) of 44 residents selected for investigation during the survey process. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Resident #32 was admitted on [DATE] with diagnoses including Acquired Absence of Left Leg Below Knee, Hemiplegia and Hemiparesis following Cerebral Infraction affecting Left Non-Dominant Side, Acquired Absence Right Leg above Knee. 1) On [DATE] at 07:41 AM the surveyor reviewed Resident # 32's care plan for Fall which was initiated on [DATE] with the Focus - Resident had an actual fall and remains at risk for falls relating to Deconditioning, Right AKA (Above the Knee Amputee), Left BKA (below the Knee Amputee), generalized weakness, history of cerebral infraction affecting left non-dominant side. Goal: Resident will not sustain injury through the review date An intervention which was initiated on [DATE] and remained active stated- Ensure that the resident is wearing appropriate footwear (non-skid socks) when ambulating or mobilizing in wheelchair An interview with the Director of Nursing on [DATE] at 9:21AM confirmed that the intervention on the care plan for Resident #32 to wear footwear was not applicable to the resident who is a bilateral amputee. On [DATE] at 9:00 AM a second review of Resident #32's care plan by the surveyor revealed that the intervention for footwear was discontinued on [DATE]. 2) Resident 91 was admitted on [DATE] with diagnoses including Congestive heart Failure, Ischemic Cardiomyopathy, Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Proximal Lower Extremity. Resident #91 Expired on [DATE] On [DATE] at 08:21 AM the surveyor reviewed the medical records for Resident #91. The Physician's order revealed that the resident was receiving an anticoagulant medication (Apixaban) twice a day for Atrial Fibrillation/Deep Vein Thrombosis. The medication order was initiated [DATE] and discontinued on [DATE]. The care plan for Resident #91's revealed that the interventions pertaining to the anticoagulant medication continued after the medication was discontinued and remained active until Resident's# 91's expiration on [DATE] (continued on next page)

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 08:12 AM the concern was brought to the attention on the DON by the surveyor. The DON confirmed the findings and stated that the staff should have revised the care plan after the medication was discontinued.

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

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49815 Based on observation, interview and medical record review it was determined that the facility failed to provide respiratory care and services appropriately. This was found to be evident for 2 Residents (#8 and # 57) out of 3 residents that were reviewed for respiratory care and services. The findings include: 1a) On 9/30/2024 at 11:18 AM the surveyor conducted a tour of Unit 100 and observed Resident #8 with oxygen in use and the oxygen tubing was not dated/labeled. In addition, the oxygen humidifier bottle that was attached to the oxygen delivery system did not have any water in the bottle and was dated 9/20/2024. The surveyor interviewed the Registered Nurse (RN) #11 who observed the humidifier bottle empty and asked what the expectation was for the oxygen humidifier bottle, and RN #11 stated that she would replace the humidifier bottle. On 10/4/24 at 10:00 AM the surveyor observed Resident #8 in bed with oxygen in place to his/her nostrils and the oxygen humidifier bottle and the oxygen tubing was dated 10/03/2024. The surveyor conducted a record review of Resident #8's medical record at 12:10 PM on 10/4/2024. The medical record review revealed that Resident #8 had physician orders for oxygen and oxygen tubing to be changed every 7 days. In addition, the surveyor reviewed the facility oxygen administration policy which indicated that oxygen tubing is to be dated/labeled. 1b) On 10/04/2024 at 10:10 AM the surveyor observed Resident #57 with oxygen in use in the hallway on Unit 100 with the oxygen emergency tank in the holder on the back of the wheelchair. The surveyor observed that Resident #57's oxygen tubing that was connected to the emergency oxygen tank was not dated. A chart review was conducted by the surveyor at 11:55 AM on 10/4/2024 and the review revealed that Resident #57 had physician orders for oxygen usage and oxygen tubing to be dated and changed every 7 days. In addition, the surveyor reviewed the facility oxygen administration policy which indicated that oxygen tubing is to be dated/labeled. The surveyor conveyed to the Regional Nurse Consultant at 1:15 PM on 10/4/2024 of these concerns with oxygen usage.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49815 Based on observations, interviews and medical record review it was determined that the facility failed to store medications appropriately. This was found to be evident in 1 (Resident #8) out of 1 resident for medication storage. The findings include: During the initial tour of Nursing Unit 100 at 11:18 AM on 9/30/2024 the surveyor observed two respiratory medication inhalers at Resident #8's bedside. The surveyor notified Registered Nurse (RN) #11 of Resident #8 with medications at the bedside and RN #11 observed the two respiratory inhalers at the bedside and stated that one of them was Albuterol and that Resident #8 had a locked drawer. The surveyor conducted a record review of Resident #8's medical record on 10/4/2024 at 07:44 AM and the review of the medical record revealed that there was not an order for medications/inhalers at the bedside. A self-administration medication assessment was completed by the nursing staff on 10/2/2024 for Resident #8. On 10/1/2024 at 08:45 AM the surveyor observed Resident #8 with five tablets in a medication cup on the meal tray on the resident's overbed table. The surveyor notified the Certified Medication Aide (CMA) #12 and the CMA observed the five medications in the medication cup on the meal tray on the Resident #8's overbed table. In addition, the surveyor interviewed the Certified Medication Aide (CMA) #12 and asked the CMA what these four medications were in the medication cup. The CMA stated that the five tablets were: Metoprolol, Mucinex, Zoloft, Aspirin, and Hydroxyzine. The surveyor asked the CMA what the expectation was for medication administration and medications left at the bedside, and the CMA stated, I should have stayed at the bedside while the Resident took his/her medications, but I have an hour to pass medications to all the Residents and how can I get these medications out to all these Residents within the timeframe. At 10:49 AM on 10/01/2024 the surveyor conveyed to the Director of Nursing (DON) the medications that were observed at Resident #8's bedside, and the interview with the Certified Medication Aide (CMA) #12. The DON stated that she would address and provide re-education on medication administration to the Certified Medication Aide (CMA) #12. On 10/4/2024 at 7:44 AM the surveyor reviewed Resident #8's medical record specifically the physician orders and the medication administration records and confirmed that Resident #8 had an order for these five medications (Metoprolol, Mucinex, Zoloft, Aspirin, and Hydroxyzine) and that these five medications were documented as administered by the Certified Medication Aide (CMA) #12.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on observation and staff interview it was determined that the facility staff failed to ensure food products were properly labeled and disposed of when they are past their expiration dates. This was observed on two tours of the kitchen. The findings include: On 9/30/24 at 8:10 AM a tour of the kitchen revealed there were several items that were either past an expiration date or their labeling was incomplete. The walk-in cooler had a container of mustard with a label indicating it was opened on 7/4 and to use by 8/4. The year was not present, but it appears to have been past the use by date. There were two containers of ricotta cheese that had expiration dates of 9/27/24. One 1-gallon container of coleslaw dressing that had a label that both a use by date and expiration date of 8/12. A second container of coleslaw dressing that was not labelled. One container of teriyaki with a use by date of 7/30. There were 4 boxes of sun cups that had a warning on the box to serve within 10 days but there was no label to indicate when they were thawed. Several containers of dressing in the cooler had black mold like growth on them. Interviewed the Dietary Manager on 10/2/24 at 10:02 AM showed him the containers of salad dressing with labels that now show the year. Also have some kind of mold like growth on the outside containers of salad dressing and mustard. Showed him the container of Ricotta cheese and asked what does X [date] mean and he said it was an expiration date. He said he would take care of all the items in question.

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

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 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.

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on observations, and interviews, it was determined that the facility failed to provide a safe, sanitary environment to prevent the development and transmission of disease and infection. This was evidenced by: 1) Staff failing to perform hand hygiene before entering the room of a resident with enhanced barrier precautions 2) Failure to keep contaminated pillows separate and away from clean pillows in the laundry room The findings include: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1) On 10/3/24 at 8:20AM during rounds, on the unit with rooms 500-514, the surveyor observed Enhanced Barrier Precautions (EBP) signage over the beds of 514b, 512b, 509a, 508b, 506a, 505b, 504a. The signage which was issued by the Center for Disease Control had instructions which included Everyone Must Clean their hands, including before entering and when leaving the room. While standing in the hallway of the unit thirty-two minutes later at 8.52 AM, the surveyor observed Staff# 4 enter one of the rooms with EBP, Room# 506a without performing hand hygiene, then at 8:56 AM Staff# 5 also entered room [ROOM NUMBER]a without performing hand hygiene. Hand Sanitizer dispensers were mounted on the walls in the hallway outside the rooms. No Personal Protective Equipment (disposable gowns, gloves and masks) storage carts were observed on the unit or outside the residents' rooms. On 10/3/ 24 at 11:10 AM the surveyor interviewed Staff#1 in the presence of the DON. How are the staff aware of EBP? We educate our staff on the placement of the signage and what it means. Signages are placed over the residents' beds in their rooms and green stickers are placed on their names on the wall outside their rooms to indicate they are on EBP. We do not put the signs outside on the residents' doors because we want to maintain a homelike environment and these signs could be up for a long time. Staff are educated to perform hand hygiene before entering and when leaving the room of a resident with EBP. The surveyor asked where the Personal Protective Equipment supplies (PPE) were kept for use on the unit. Staff#1 stated that the PPE supplies were kept in carts in the hallways. The Surveyor notified Staff#1 that on 10/3/24 at 8:52 AM and 8:56 AM two GNAs on the unit were observed entering room [ROOM NUMBER]a without performing hand hygiene. Also, no PPE carts were observed in the hallway or on the unit with rooms 500-514. On 10/4/24 at 9.00AM surveyor observed a cart in the hallway with PPE supplies on the unit with rooms 500-514 (continued on next page)

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 10/07/24 at 08:48AM the surveyor observed several pillows on a 3-tier rack in the laundry room. Some of the pillows were individually placed in clear plastic bags while others were sitting on the rack uncovered. The surveyor inquired about the pillows from Staff#21, Director of Housekeeping. Staff #21 stated that when the pillows are cleaned, they are placed in plastic bags and put on the rack. The clean pillows were the ones covered in plastic bags while the uncovered pillows were the ones that needed to be cleaned. The surveyor asked whether it was the facility's practice to have clean and contaminated pillows together on the same rack. Staff#21's response was I guess and did not indicate to the surveyor, the infection control process for the cleaning of pillows. On 10/08/24 at 08:10 AM the surveyor revisited the laundry room and observed several pillows on the 3-tier rack individually covered in clear plastic bags. The surveyor did not observe any pillow without a clear plastic cover on the rack.

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

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50504 Based on observations, and interviews, it was determined that the facility failed to keep a sanitary environment. This was found evident on 1 of 3 floors observed in the laundry room area. The findings include: On 10/07/24 at 08:48AM the surveyor did a walk through the laundry room. Staff #22 and Housekeeping Director, Staff #21 were present. The surveyor observed the floor tiles in the room with the washing machines were visually dirty and sticky with a brown colored substance. On the floor in front of the washing machines were two large, rusty drain pit covers. Surrounding the drain pit covers were an accumulation of dirt. Chemicals for the washing machines were in buckets attached to hoses sitting on a platform covered with thick powder like white substance. The thick white substance was also scattered on the floor next to the platform. In an interview regarding the condition of the room Staff #22 agreed that the room needed cleaning. On 10/08/24 at 08:10 AM the surveyor did a second observation of the laundry room with the Maintenance Director and the Administrator. The room was in the same condition as the surveyor observed on 10/07/24 at 08:48AM. The surveyor reviewed the findings of the dirty floor and rusty drain covers with the Administrator and Maintenance Director. The Administrator commented, maybe we could use a power wash for cleaning, it is an old building.