

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on interviews and record reviews, it was determined that the facility failed to ensure residents were offered the opportunity to formulate Advanced Directives. This was found to be evident for 6 (#1, #2, #90, #11, #7, & #8) out of 7 residents reviewed for Advanced Directives planning during the recertification survey. The findings include:1) On 02/25/2026 at 9:17 AM, the surveyor requested the Director of Social Services provide documentation that Residents #1, #2, and #90 were provided opportunities to formulate Advanced Directives.</p> <p>On 02/25/2026 at 11:58 AM, The Director of Social Services stated that he was unable to find documentation that Advance Directives were offered to Residents #1, #2 and #90.</p> <p>2) On 2/24/26 at 1:50 PM, the surveyor reviewed Resident #11's medical record. The review revealed that Resident #11 was admitted to the facility in April of 2025 and was deemed capable of making his/her own medical decisions. On further review there was no documentation to indicate if Resident #11 was asked if he/she would like to formulate them.</p> <p>On 2/26/26 at 8:41 AM, the surveyor conducted an interview with the Director of Social Service Staff #14. During the interview Staff #13 stated he also could not find documentation to indicate advanced directives were offered.</p> <p>On 2/26/26 at 9:47 AM, the surveyor conducted a follow-up interview with Staff #14. During the interview Staff #14 stated that he had reviewed and assisted Resident #11 in initiating advanced directives</p> <p>3) On 02/25/2026 at 8:13 AM, review of Resident #7's medical record failed to reveal indication that they had an advanced directive nor that they were asked about advanced directives upon admission.</p> <p>4) On 02/25/2026 at 8:20 AM, review of Resident #8's medical record failed to reveal indication that they had an advanced directive nor that they were asked about advanced directives upon admission.</p> <p>On 02/25/2026 at 10:10 AM, an interview with the Director of Social Services (Staff #14) revealed that each resident who was admitted to the facility was asked if they had an advanced directive, and if not the facility would ask if they would like to be provided information to make one. The surveyor indicated they were unable to find documentation regarding advanced directives for Resident #7 and #8, and Staff #14 indicated he would provide documentation.</p> <p>On 02/25/2026 at 11:48 AM, Staff #14 provided a document titled, Social Service Initial Evaluation, dated 2/28/2024 for Resident #7 which indicated the resident did not have an advanced directive, but failed to reveal indication that the facility offered the resident information to create one. (continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At the same time, the surveyor was provided the same document titled, Social Service Initial Evaluation, dated 9/10/2025 for Resident #8 which failed to indicate advanced directives were addressed with the resident as it did not indicate whether the resident had an advanced directive or not, there was only mention of the resident's code status.</p> <p>On 02/25/2026 at 11:51 AM, an interview with Staff #14 revealed he was unable to provide further documentation for advanced directives for Resident #7 and #8. The surveyor reviewed the concern and he indicated that he understood.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on record review and staff interview, it was determined that the facility failed to ensure notice of resident transfers and discharges were submitted to the representative of the Office of the State Long Term Care Ombudsman. This deficient practice was identified during annual survey and had the potential to affect all residents who experienced a transfer or discharge. The findings include: On 02/27/2026 at 9:40 AM, during an interview with the Administrator, the surveyor requested documentation indicating that the Ombudsman has been notified of monthly transfers and discharges between October 2025 to December 2025. The Administrator stated that she would gather the requested information and follow up with the surveyor. At 12:30 PM, the Administrator followed up with the surveyor and stated that the facility had failed to submit monthly transfer and discharge notices to the Ombudsman. The surveyor inquired when the Ombudsman was last notified of resident transfers and discharge. The Administrator stated that notices had not been submitted since she began employment at the facility in September 2025.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Based on interviews, observations, and record reviews, it was determined the facility failed to ensure a residents right to self-determination by honoring the resident's preference regarding the timing of blood sugar monitoring. This deficient practice was evident for one (#4) resident reviewed for self-determination during the annual survey. The findings include: On 02/24/26 at 7:30 AM, the surveyor conducted an initial tour of the facility. At 8:07 AM, the surveyor asked a Certified Medication Aide (CMA) #4 what time breakfast trays typically arrive to the unit. The CMA #4 stated trays usually arrive between 8:30AM and 9:00AM. On 02/24/26 at 8:10 AM, the surveyor observed Resident #4 in their room. At 1:37 PM, an interview with Resident #4 revealed the resident had concerns regarding elevated blood sugar levels. On 02/25/26 at 11:31 AM, a review of Resident #4s Medication Administration Record (MAR) revealed a physician order to check fasting blood sugar daily at 6:00 AM. Between 02/01/2026 to 02/25/2026, the resident refused fasting blood sugar checks on 21 of 24 occasions. A separate order to check bedtime blood sugar daily at 10:00 PM, revealed the checks were completed on 23 of 24 occasions. A review of progress notes from Nephrology, the Primary Physician, and Endocrinology Nurse Practitioner from January and February 2026 all documented that the resident refused blood sugar checks. At 11:58 AM, during an interview, Resident #4 stated they refused blood sugar checks because staff were waking them between 5:00 AM-6:00 AM, and they did not want to be woken that early. The resident further stated they had communicated this to staff on multiple occasions, but nothing had been done. At 12:26 PM, during an interview with the Director of Nursing (DON), she confirmed she was aware of Resident #4s history of refusing blood sugar checks but stated she did not know the reason for refusals. The surveyor informed the DON of the resident's preference. On 03/02/2026, at 12:04 PM, during an interview, the Endocrinology Nurse Practitioner (NP) #33 acknowledged he was aware of the resident's history of refusing blood sugar checks but stated he did not know the reason. The survey informed the NP of the resident's preference. At 2:46 PM, a review of Resident #4s medical record revealed a new progress note from NP #33 recommending the fasting blood sugar checks be conducted at 7:30 AM per the resident's preference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on observations and staff interviews, it was determined that the facility staff failed to provide services necessary to maintain a sanitary environment. This was observed on 1 (room [ROOM NUMBER]'s) bathroom during the initial tour. The findings include: On 2/24/26 at 10:29 AM, the surveyor observed a toilet plunger next to the toilet inside a plastic bag in room [ROOM NUMBER]. On further observation a brown liquid substance was noted coating the bottom of the plastic bag. On 2/26/26 at 7:01 AM, the surveyor conducted an interview with the Maintenance Director Staff #17. During the interview Staff # 17 stated that when there is a plunging need identified, maintenance will get a work order to fix the concern. He confirmed that plungers should not be kept in soiled plastic bags in Resident's bathrooms and would remove it from room [ROOM NUMBER]'s bathroom.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>*Based on record review and interview, it was determined that the facility failed to ensure a resident's PRN (as needed) psychotropic (mental health) medication order was no longer than 14 days without a provider's rationale. This was evident for 1 (Resident #10) of 5 residents reviewed for unnecessary medication. The findings include: On 02/25/2026 at 11:17 AM, review of Resident #10's medical record revealed an active order for Hydroxyzine (a medication that calms anxiety/stress) 10mg every 12 hours as needed for anxiety, with a start date of 1/23/2026. On 02/26/2026 at 9:44 AM, an interview with the Director of Nursing regarding PRN psychotropic medication orders revealed that they should be limited to 14 days at a time unless the provider had given a rationale for the extended need. The surveyor requested a copy of Resident #10's active order and the psychotropic medication policy. On 02/26/2026 at 11:42 AM, the surveyor was provided the documents requested above. Review of the document titled, Antipsychotic Medication Use, revealed indication that PRN psychotropic medications should be limited to 14 days unless a provider documented a rationale for the extended order. On 02/26/2026 at approximately 11:45 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood the concern.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on interviews and record review, it was determined that the facility failed to ensure residents were provided with summaries of their baseline care plans. This was found to be evident for 1 (#13) out of 8 residents reviewed for care planning during the recertification survey. The findings include: During a record review on 02/26/2026 at 12:11 PM, documentation could be found that a baseline care plan was initiated, however there was no documentation that the care plan was reviewed and a copy provided to Resident #13 or the responsible party. The Administrator was requested to provide the information to the surveyor. On 02/26/2026 at 11:46 AM, the Administrator stated that she was unable to find documentation of a baseline care plan being given to Resident #13 and/or the responsible party.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>*Based on interview and record review, it was determined that the facility failed to ensure residents received quarterly care plan meetings. This was evident for 4 (Resident #7, #8, #16, and #129) of 4 residents reviewed for care planning. The findings include: 1) On 02/24/2026 at 8:02 AM, an interview with Resident #7 revealed that the last time they had a care plan meeting was during the previous summer. 2) On 02/24/2026 at 9:22 AM, an interview with Resident #129 revealed that they were unaware that the facility had care plan meetings and further indicated he/she had never participated in one at the facility. 3) On 02/24/2026 at 10:07 AM, review of Resident #8's medical record failed to reveal indication of when their last care plan meeting was. 4) On 02/24/2026 at 1:31 PM, an interview with Resident #16 revealed he/she was unsure when their last care plan meeting was. On 02/24/2026 at 1:47 PM, review of Resident #16's medical record revealed a progress note dated 1/7/2026 at 1:16 PM, that indicated a care plan meeting was scheduled to be held that day, but that the resident was admitted at the hospital at the time. Further review of the medical record failed to reveal indication that the care plan meeting was rescheduled and completed. On 02/25/2026 at 10:17 AM, an interview with the Director of Social Services (Staff #14) revealed that care plan meetings were held for residents at least quarterly, after the comprehensive assessment. During the same interview, the surveyor asked Staff #14 to provide documentation of the last care plan meeting for the five residents noted above. On 02/25/2026 at 11:48 AM, review of the last care plan meeting documentation provided by Staff #14 revealed: Resident #7's last care plan meeting was 8/6/2025. Resident #129's last care plan meeting was 9/3/2025. Resident #8's last care plan meeting was 9/25/2025. Resident #16's last care plan meeting was 7/23/2025. On 03/02/2026 at approximately 9:00 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood the concern.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record reviews, interviews, and observations, it was determined that the facility staff failed to ensure services were provided in accordance with professional standard of practice when staff failed to administer medications according to physician orders. This deficient practice was evident for two (#129, #49) of two residents review for medication administration during the annual. The findings include: 1) On 02/27/2026 at 9:54 AM, a review of Resident #129's medical record revealed the resident was admitted to the facility with multiple diagnoses, including opioid dependence. A review of the Medication Administration Record (MAR) for February 2026 revealed a physician's order for Oxycodone 10mg by mouth every six hours as needed for a pain rating between 7-10. Further review of the February 2026 MAR revealed that Oxycodone 10mg was administered to Resident #129 on 23 occasions when the pain score was documented between 0-6. A review of January 2026 MAR revealed Oxycodone 10mg was administered 24 occasions, and a review of the December 2026 MAR revealed Oxycodone 10mg was administered 17 occasions outside of ordered parameters. On 03/02/2026 at 7:36 AM during an interview with the Director of Nursing (DON), the DON stated that nursing staff are expected to follow physician's ordered parameter when administering medication. The surveyor informed the DON that a review of Resident #129's MAR between December 2025-February 2026 revealed multiple occurrences in which Oxycodone 10 mg was administered outside physicians ordered parameters. The DON reviewed the findings with the surveyor and acknowledged the MAR documentation. 2) On 02/26/2026 at 10:08 AM, during an interview with Licensed Practical Nurse (LPN) #22 the surveyor observed an empty medication blister card for Resident #49's Pregablin at the nurse's station. The LPN stated she was in the process of contacting the pharmacy because the resident ran out of Pregablin. The LPN further explained that the facility's process for controlled substances is to request a refill when the medication reaches eight tablets; however, staff failed to request the refill prior to the medication running out. An interview was conducted with the DON at 10:28 AM. The DON confirmed that facility staff are expected to contact the pharmacy to request a refill before medications run out, specifically for controlled substances that require a pharmacy refill request. A review of Resident #49s MAR at 10:41 AM revealed two active physician orders for Pregablin. The first order directed staff to administer Pregablin 100mg by mouth twice a day at 8:00 AM and 4:00PM. The second order directed staff to administer Pregablin 150 mg by mouth at 8:00PM. At 2:09 PM, LPN #22 informed the surveyor that she had not contacted the pharmacy to request a refill for Resident #49's Pregablin. At 2:24 PM, the DON informed the surveyor that Resident #49's Pregablin had been ordered and was expected to arrive during the pharmacy's next schedule delivery run. On 02/27/2026 at 9:40 AM, the surveyor requested to review the medication audit report for Resident #49 dated 02/26/2026. A review of the documentation revealed that Resident #49 received the scheduled 4:00PM dose of Pregablin 100mg and the scheduled 8:00PM dose of Pregablin 150mg at 8:33 PM. Further review of the medical record failed to reveal documentation indicating the physician was contacted for guidance regarding the delayed administration of medication. On 03/02/2026 at 7:23 AM, the surveyor informed the DON of the concerns regarding the administration of Resident #49's Pregablin. The DON acknowledged the concern and stated that disciplinary action has been taken, and education was provided to the nurse involved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on interviews and record reviews, it was determined that the facility staff failed to ensure residents received services to maintain or improve the ability to perform Activity of Daily Living (ADL). This deficient practice was evident for one (#4) resident reviewed for assistive devices during the annual survey. The findings include: On 02/24/2026 at 1:33 PM, during an interview with Resident #4, the resident reported that they have difficulty hearing and stated that they were evaluated last summer and informed they were a candidate for hearing aids. The resident further reported that there had been no follow up. During the interview, the surveyor observed that Resident #4 spoke loudly which is consistent with the resident's report of hearing loss. On 02/26/2026 at 11:54 AM, the surveyor conducted a review of Resident #4's medical record, which failed to reveal documentation indicating the resident hearing had been assessed. On 02/27/2026 at 7:37 AM, during an interview with the Director of Nursing (DON), the surveyor inquired about Resident #4's hearing screening from summer 2025. The DON stated that she believed the resident's hearing has been screen in July 2025 and reported she would follow up after she locates the documentation. On 02/27/2026, the DON provided the surveyor with Resident #4's hearing assessment dated [DATE]. A review of the document indicated the reason for referral was the resident's complaint of newly decreased hearing. The clinical findings documented that the resident has moderate to severe mixed hearing loss in the right ear and moderate to severe sensorineural hearing loss in the left ear. The assessment included recommendations for staff to communicate using clear, slow speech with visual cues, and to favor the resident's left ear when speaking. The document further indicated that the resident was a candidate for hearing aids and recommended a medical consultant to obtain clearance for hearing aid use. After reviewing the assessment with the DON on 02/27/2026 at 7:39 AM, the surveyor inquired about the facility's process for addressing outside consult recommendations for residents. The DON explained that consult recommendations are forward to the Unit Manager or Assistant Director of Nursing (ADON) for review. The Unit Manager or ADON are responsible for reviewing the recommendations and notifying the provider. If the provider agrees with the recommendations, staff are expected to enter the new physician orders within 24 hours. The DON stated there was no documentation indicating the physician had been notified of the hearing recommendations for Resident #4.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was found evident in 2 (Resident #63, #9) out of 5 residents reviewed for Activity of Daily Living (ADL) cares. The findings include: 1. On 2/24/26 at 10:17 AM, the surveyor interviewed Resident #63. During the interview Resident #63 reported that he/she had to wait a long time to get cleaned up. On 2/26/26 at 11:07 AM, the surveyor requested shower records for Resident #63 On 2/26/26 at 2:30 PM, the surveyor reviewed the shower documentation with the acting Director of Nursing (DON). During the review it appeared that Resident #63 was scheduled to receive showers on Mondays and Thursdays. It was also noted that Resident #63 had been out of the facility several days in the middle of February (those days were x'd out), however the days when Resident #63 was in the facility, shower days were open for documentation On Monday 2/3/26 and Thursday 2/19/26 the shower day was coded NA (not applicable). On 2/5/26 and 2/23/26 the shower day was coded that the Resident refused. The surveyor asked the acting DON why on two of the shower days were coded not applicable. The acting DON stated she would look into the shower documentation. On 2/26/26 at 3 PM, the acting DON stated she could not find any additional documentation to indicate a shower was offered/provided to Resident #63 on his/her 2/3/26 and 2/19/26 shower days. 2. On 2/24/26 at 9:25 AM, the surveyor conducted an interview with Resident #9. During the interview Resident #9 stated that he/she was only offered to shower once a week however was scheduled to shower twice a week on Mondays and Thursdays. On 2/25/26 at 6:34 AM, the surveyor requested shower documentation for Resident #9 for February of 2026. On 2/25/26 at 1:32 PM, the surveyor reviewed the shower documentation. Showers were documented as given on 2/6/26, 2/9/26 and 2/16/26 with a tub bath documented on 2/19/26. No refusals were noted. On further review it was noted that Resident #9 was assessed to need partial to moderate assistance on the Minimum Data Set showering assessment dated [DATE]. On 2/26/26 at 8:09 AM, the surveyor conducted an interview with Unit Manager #40. During the interview UM #40 confirmed that Resident #9 was scheduled to receive showers twice a week and did not recall any refusals from him/her. She confirmed that the documentation demonstrated that Resident #9 received only one shower per week even though he/she was scheduled for two.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>Based on record review and interviews it was determined that the facility failed to identify and provide appropriate interventions and notifications for a resident's condition. This was found evident of 2 (Resident #63 & 4) out of 2 residents reviewed for insulin during the survey. The findings include:</p> <p>1) On 2/24/26 at 10:18 AM, the surveyor conducted an interview with Resident #63. During the interview Resident #63 stated that he/she thought that he/she did not receive the right amount of insulin because his/her blood sugars were off.</p> <p>On 2/26/26 at 10:48 AM, the surveyor reviewed Resident #63's Medication Administration Record (MAR). The review revealed Resident #63 had an order for Humalog (fast acting insulin) 6 units ordered to be given subcutaneously with meals (to cover the carbohydrate in the meal) for diabetes mellitus. On 2/24/26 the administration was coded with 14.</p> <p>On 2/26/26 at 1:48 PM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor asked the acting DON what the code 14 meant. The acting DON stated it meant parameters out of range. The surveyor confirmed that there was no range on the Humalog orders and medication should have been given with Resident #63's meal. The surveyor further reviewed the blood glucose documented at 6:30 am that same day and noted it was 89 and at 11:30 am (after not receiving the insulin with the meal) the blood glucose was 400.</p> <p>The surveyor next reviewed Resident #63's blood glucose level on 2/25/26. At 11:30 AM, Resident #63's blood glucose was 411 and at 8 PM it was 449. An additional order for correction dose insulin (per scale) was written for Resident #63. The instructions stated to give 8 units of Humalog if blood glucose was between 351-400. This insulin (correction dose per scale) was to be given with meals and along with the covering carbohydrate dose ordered to cover the meal (the 6 units as ordered above). The instructions further stated that if blood glucose was greater than 400 to call the provider. Both of these administrations were labeled 9, see progress note but there was no note to indicate what the response was.</p> <p>The surveyor continued the interview with the acting (DON) and asked if the staff contacted the providers with the two-blood glucoses greater than 400. The acting DON stated that she had no documentation to demonstrate that the staff called the providers per instructions in the medication order.</p> <p>2) On 02/24/2026 at 1:33 PM, during an interview, Resident #4, expressed concerns regarding elevated blood glucose levels.</p> <p>On 02/25/2026 at 11:39 AM, a review of Resident #4's Medication Administration Report (MAR) for February 2026 revealed bedtime blood glucose readings documented as high as 410 mg/dL during 23 documented reading. Further review of the blood glucose readings from November 2025 through January 2026 revealed readings ranging from 100mg/dl to 328mg/dl.</p> <p>A review of the medical record did not reveal documentation indicating the physician had been notified of blood glucose reading at or above 400 mg/dl.</p> <p>On 02/25/2026 1:31 PM, during an interview, the surveyor informed the Director of Nursing (DON) of resident concerns and reviewed the February 2026 blood glucose readings. (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor asked what the facility's expectation is for staff when abnormal blood glucose levels are identified. The DON stated that nursing staff are expected to notify the physician. The DON acknowledged that blood sugar readings at or above 400 mg/dL should have been reported to the physician. The surveyor requested documentation indicating the physician had been notified of the resident's blood glucose reading at or above 400 mg/dL.</p> <p>On 03/03/2026, the surveyor followed up with the DON regarding physician notification. The DON stated that there was no documentation indicating the physician had been notified of the elevated blood glucose readings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>Based on interviews and record reviews, it was determined that the facility failed to ensure services were provided to address a resident's hearing needs. This deficient practice was evident for one Resident (#48) reviewed for hearing services during the annual survey. The findings include: On 02/24/2026 at 10:39 AM, during an interview, Resident #48 reported that they had requested a hearing screening some time ago; however, the resident stated that the request had not been addressed and they were still waiting to receive a hearing test. A review of Resident #48's medical records on 2/26/2026 at 12:06 PM failed to reveal documentation of a hearing screening appointment or consultation. On 02/27/26 at 12:51 PM, during an interview with the Director of Nursing (DON), the surveyor inquired about outside consultants used by the facility to assess resident's hearing, vision, and dental needs. The DON reported that the facility uses a company consultant service. The surveyor informed the DON of resident #48's concern. The DON stated that she would investigate the matter and follow up with the surveyor. On 03/02/2026 at 7:38 AM, the surveyor followed up with the DON regarding the status of Resident #48's hearing consultation. The DON acknowledged that the facility failed to submit the required Audiology documentation to the hearing consultant for the resident in July 2025. As a result, the resident did not receive the hearing screen. The DON provided the surveyor with a consultation form for Resident #48 dated 02/27/2026.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, medical record review and interviews, it was determined the facility staff failed to clarify appropriate care measures to prevent complications from a hand contracture. This was evident for 1 (resident #74) of 1 resident reviewed for mobility. The findings include: A contracture is an abnormal shortening of muscle, tendons, skin, or tissues, causing the resistance to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. On 2/24/26 at 9:38 AM, the surveyor observed Resident #74 resting in bed and noted his/her left hand was contracted. On further observation the surveyor noted a hand splint was on the bedside table next to the resident's bed. On 2/26/26 at 11:20 AM, again the surveyor observed Resident #74 in bed and the hand splint on the bedside table. On 2/26/26 at 11:51 AM, the surveyor reviewed Resident #74's orders. The review revealed two orders for his/her left hand splint. On 11/4/25 an order was written for Resident #74 to have palm guard splint to left hand at all times except bathing and hygiene activities. On 11/5/25 and order was written for Resident #74 to wear a left palm protector 6-8 hours or as long as tolerated everyday. Next the surveyor reviewed Resident #74's February and March Treatment Administration Records (TAR). The review revealed that both orders were being documented as completed. On 2/26/26 at 11:57 AM, the surveyor reviewed Resident #74's care plan. A care plan was written that Resident #74 refused to wear a palm guard at times. However, the documentation on the TARs did not capture this behavior. On 3/2/26 at 7:41 AM, the surveyor reviewed Resident # 74's Occupational Therapy (OT) discharge notes dated 1/23/26. The discharge recommendations were to have a palm guard on the affected hand at all times, 27/7 care. Again on 3/3/26 at 7:43 AM, the surveyor observed Resident #74 with his/her splint not on but on the floor next to the bed. On 3/3/26 at 8:24 AM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor showed the acting DON the documentation that both splint orders were being signed off on, the observation of Resident #74 not having the splint on, as well as the OT discharge recommendations. The acting DON stated that Resident #74 should not have two conflicting orders and the most recent recommendation should be the active. She further stated that the TAR should reflect the care provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observations, interviews, review of facility's policy and record review, it was determined that the facility failed to provide appropriate treatments to prevent complications for a resident who required enteral nutrition. This was evident for 1 (Resident #12) out of 1 resident reviewed for tube feeding during the survey. The findings include: Enteral nutrition, also known as tube feeding, is a way to deliver dietary needs directly to the stomach or small intestine. A gastrostomy tube or (g-tube) is used when nutrition is delivered to your stomach. A common g-tube placed is called a percutaneous endoscopic gastrostomy (PEG) tube. On 2/26/26 at 11:24 AM, the surveyor observed a bag of water handing along side resident #12's tube feeding bottle. The bag labeled H2O (water) was dated 2/23/26 and timed 2 PM. The tube feeding bottle was dated 2/25/26 and timed 11 PM. On 2/27/26 at 8:50 AM, the surveyor observed Resident #12's tube feeding bag was dated 2/27/26. However, the water bag had what appeared to be the same label as the day before except over the date a 7 was placed over the 3 and 7-11 was written over the 2 PM. On 2/27/26 at 9:50 AM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor asked what the expectation was for changing tube feeding and water hydration bags. The acting DON stated that they both should be changed every 24 hours. The surveyor reviewed the observation with the acting DON. The acting DON stated that the water hydration bag should have been changed and relabeling the bag was not the accepted practice. The surveyor next reviewed the facility policy titled Enteral Feeding -Safety Precautions. In administration set changes it states, change sets every 24 hours and as needed. It further states, label tubing with date and time of change.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined the facility failed to 1) have a designated nurse supervisor/charge nurse and 2) have sufficient staff dispense medications in a timely manner. This was found to be evident during one early hour observation and during an observation of medication administration. Findings include: 1) On 3/2/26 at 6:09 AM, the surveyor asked Licensed Practical Nurse (LPN) #31 who the night shift supervisor was. LPN #31 stated that she was not sure but would ask her coworker LPN #41. The surveyor followed LPN #31 to the Nurses' station between the 500 and 100 hallways where LPN #41 was located. On 3/2/26 at 6:11 AM, the surveyor asked LPN #41 who the night shift supervisor was. LPN #41 stated she did not believe there was a nighttime supervisor last night but the day time supervisor would be in shortly. On 3/2/26 at 7:54 AM, the surveyor interviewed the acting Director of Nursing (DON). The surveyor relayed the concerns that the nighttime staff was unaware of who the night time supervisor was. The acting DON stated she would look into the concern. On return the acting DON stated that LPN #31 was the nighttime supervisor and was given the supervisor materials. The acting DON did not understand why LPN #31 did not know she was assigned supervisor. The surveyor reviewed the staffing sheet with the acting DON and noted that there was no designated supervisor on the staffing sheet for night shift while on other days the supervisor was listed. 2) On 3/2/26 at 8:24 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 push a medication cart down the hall. The surveyor asked LPN #5 if she was administering medications. She stated that she would be today but normally a Certified Medication Assistant (CMA) would do it. She explained the CMA was scheduled off. LPN #5 stated she was responsible for both jobs, nurse and medication administrator, and that before she could start, she had to provide nursing cares for a resident down the hallway. LPN #5 left the cart to assist a resident. On 3/2/26 at 8:29 AM, LPN #5 walked past the medication cart and noted a call light on. At this time, she enters into the room and responds to the Resident's needs and then proceeds to the nurses' station. LPN #5 was then seen walking back into a resident's room and back to the nurses' station with a laboratory specimen. On 3/2/26 at 8:42 AM, LPN# 5 returns to the medication cart. At this time Geriatric Nursing Assistant (GNA) #42 walked up to LPN #5 and asked to get report on her assignment. On 3/2/26 at 8:55 AM, the surveyor observed LPN #5 now be able to start medication administration. LPN then prepared and administered medications to Resident #82. This was 31 minutes from when LPN #5 first pushed the medication cart down the hallway to start medication administration. On 3/2/26 at 9:11 AM, the surveyor observed LPN #5 prepared and administered medications to Resident #24. At this time LPN #5 was alerted by another staff that the resident in room [ROOM NUMBER] needed LPN #5. At this time LPN #5 left the medication administration cart. On 2/3/26 at 9:17 AM, LPN #5 returned to prepare and administer medications to Resident # 58. On 3/2/26 at 9:40 AM, LPN #5 prepared and administered medications to Resident #49. Some of the medications scheduled administration times were for 8am. The medications were administered an hour and 40 minutes after the scheduled time. Upon exiting Resident #49's room two residents came to LPN #5 and request their medications. One asking to have it so now he/she could attend the 10 AM, coffee hour. On 3/2/26 at 1:48 PM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor relayed the staffing concerns that during the medication administration the nurse was delayed in administration medications due to having to attend to resident needs on top of administrating medications.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview with facility staff, it was determined that the facility failed to post all of the required staffing information on a daily basis. This was evident on 1 out of 6 days on the survey. The findings include: On 3/2/26 at 6:06 AM, the surveyor observed the Plexiglas tray on the front desk empty. On the previous days of the survey this tray had staffing hours posted. On 3/2/26 at 6:09 AM, the surveyor asked Licensed Practical Nurse (LPN) #31 who the night shift supervisor was. LPN #31 stated that she was not sure but would ask her coworker LPN #41. The surveyor followed LPN #31 to the nurses' station between the 500 and 100 hallways where LPN #41 was located. On 3/2/26 at 6:11 AM, the surveyor observed the whiteboard in the nurses' station, where the assignments had been posted during the other days of the survey, and noted it was blank. The surveyor asked LPN #41 if the assignments should be posted on the board. LPN #41 stated that the board was wiped clean so the unit clerk could put up the new assignment. The surveyor asked if the unit manager was on site. LPN #41 stated she had not shown up yet. The surveyor brought up the concern that staffing was not posted as required and asked who the night shift supervisor was. LPN #41 stated she did not believe there was a nighttime supervisor last night and that the daytime supervisor would be in shortly. On 3/2/26 at 7:54 AM, the surveyor interviewed the acting Director of Nursing (DON). The surveyor relayed the concern that there was no staffing posted with staffing hours when entering and on the unit. The DON confirmed the posted staffing should have been available.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observations, record reviews, and interviews, it was determined that the facility failed to administer medications according to procedures that ensure accurate dispensing. This was evident for 1(Resident #82) out of 4 residents reviewed for medication administration. The findings included:On 3/2/26 at 8:55 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 prepare medications for Resident #82. During the preparation LPN #5 pulled Resident #82's bupropion hydrochloride extended-release oral tablet 150 MG (antidepressant) and placed one tablet into the medication cup with Resident #82's other medications. Next the surveyor observed LPN #5 administer the medications to Resident #82. Next the surveyor reconciled the medications administered observation to Resident #82's medication orders. The review revealed Resident #82 had an order for 3 tablets of bupropion hydrochloride extended-release oral tablet 150 MG with instructions to give that dose once a day. On 3/2/26 at 1:14 PM, the surveyor conducted an interview with LPN #5. During the interview the surveyor reviewed Resident #82's bupropion order with LPN #5. After review LPN #5 stated that she didn't realize that she had only given Resident #82 one tablet instead of 3 and that she would need to administer two additional tablets to give the dose that was ordered.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on review of the clinical record and staff interview, it was determined that the facility staff failed to adequately monitor a resident's drug regimen which allowed an unnecessary duplicate order for medication. This finding was evident for 1 (Resident #49) of 6 residents reviewed for unnecessary medications during the survey. The findings include: On 3/2/26 at 9:40 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 prepare medications for Resident #49. During the preparation LPN #5 pulled Resident #49's Cholecalciferol (Vitamin D) tablet of 1000 units. Next the surveyor observed LPN #5 administer one tablet of Vitamin D to Resident #49. Following the observation the surveyor reconciled the medications administered observation to Resident #49's medication orders. The review revealed Resident #49 had two orders for Cholecalciferol 1000-unit table. The two orders, even though duplicate, gave the impression to give 2, 1000-unit tables, one for each order. There were two areas to document the medication on the Medication Administration Record (MAR) and it appeared both areas were marked as given even though the surveyor observed LPN #5 give one dose. On 3/2/26 at 1:14 PM, the surveyor conducted an interview with LPN #5. During the interview the surveyor reviewed Resident #49's Cholecalciferol order with LPN #5. After review, LPN #5 stated that she had only given one dose because she noticed the duplicate of order. She further stated that she was going to contact the provider later to remove the duplicate of order but had not yet contacted them. On 3/3/26 at 1:48 PM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor showed the acting DON the duplicate of order. The acting DON stated that on review of the order the physician entered the order once but checked two routes in error, allowing the order to show up twice on the MAR. She stated that she had already contacted the provider, clarified the order, and updated it so it would only be administered once per intention. The surveyor reviewed the additional concern that the duplicate order was in since February 13th and only now was clarified. The acting DON agreed the delay in addressing the duplicate order was concerning.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility's policy and interviews with staff, it was determined that the facility failed to properly store a Resident's medication. This was found evident on 1 random observation during the survey. The findings include: On 2/27/26 at 8:57 AM, the surveyor observed Certified Medications Assistant (CMA) #4 walking between two medication carts in the 100's hallway. One of the medication carts was noted to have turned front side against the wall between room [ROOM NUMBER] and 111. On 2/27/2026 at 9:10 AM the surveyor observed a nurse and CMA #4 had walked into the resident's rooms and were no longer in the hallway. Next the surveyor walked to the medication cart pushed against the wall. The surveyor was able to open the side drawer which contained colestipol oral suspension, lactulose and lidocaine patches. The top draw contained multiple bottles of floor stock medication. The second draw contained bubble packs of Resident's medications. The third drawer contained a personal water bottle along with additional medications. On 2/27/26 at 9:13 AM, the surveyor conducted an interview with CMA #4 as she walked over to the cart. CMA #4 confirmed that she was responsible for the medication cart. She further stated that she was supposed to lock the door before leaving it and was also not supposed to keep personal time in the cart. She stated that she turned the cart to the wall because she was returning to it shortly and had to share keys with the other nurse. On 2/27/26 at 9:16 AM, the surveyor conducted an interview with the acting Director of Nursing (DON) and made her aware of the observations. The acting DON stated that all staff should have their own keys and that the medications carts should be locked when unattended. She further confirmed that personal items should not be stored in the med cart. On 2/27/26 at 10:53 AM, the surveyor reviewed the policy titled, Medication Storage. The policy states, compartments, such as, medication carts, containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on interview and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 2 (Resident #74 and #90) of 2 residents reviewed for dental services during the survey. The findings include: 1) On 2/26/26 at 1:33 PM, the surveyor reviewed Resident #74's medical record. The review revealed that on 1/31/26 an order was placed for Resident #74 to have orajel to be given every 6 hours as needed for tooth pain. Additionally, an order was placed on 2/6/26 that stated Resident #74 had a dental appointment made for early March. It was also noted that on 11/4/25 Resident #74 had an order for several consulting services to be consulted as needed. Dental was listed as one of the consults.</p> <p>Next the surveyor reviewed the progress notes. A progress note written on 11/27/25 stated the reason for the visit was to follow up on tooth pain. It further stated that Resident #74 was treated with Motrin (ibuprofen) for two to three days and the tooth pain had resolved.</p> <p>On 12/28/25 a progress note was written with one of the reasons for the visit noted as dental pain. The note stated Resident #74 was having intermittent sharp lower anterior (front) tooth pain without fever, swelling or drainage. The note further advised to arrange a dental evaluation for a suspected odontogenic source.</p> <p>The next several providers' notes documented that Resident #74 had a history of tooth pain and that a dental consultation was pending. Date of service 12/31/25 reason for visit -dental pain dental consult pending</p> <p>Date of service 1/3/25 reason for visit &ndash; dental pain dental consult pending</p> <p>Date of service 1/6/26 reason for visit &ndash; dental pain dental consult pending</p> <p>Date of service 1/8/26 reason for visit &ndash; dental pain dental consult pendingDate of service 1/10/26 reason for visit &ndash; dental pain dental consult pendingDate of service 1/17/26 reason for visit &ndash; dental pain dental consult pending</p> <p>Date of service 1/20/26 reason for visit &ndash; dental pain, arrange dental evaluation for source control and treatment planning.</p> <p>Date of service 1/22/26 reason for visit &ndash; dental pain, arrange dental evaluation for source control and treatment planning.Date of service 1/23/26 pain consult -dental discomfort is resolved and dental evaluation is pending.</p> <p>Next the surveyor reviewed a change of condition written on 1/31/26 at 7:19 PM by Licensed Practical Nurse (LPN) #40. The change of condition stated that Resident #74 reported having extreme toothache. The recommendations by the provider were to apply orajel as needed to relieve tooth pain.</p> <p>On 2/26/26 at 3:04 PM, the surveyor requested any dental consult Resident #74 had arranged after the 11/27/25 documentation of dental pain and recommendation for a dental consultation.</p> <p>On 2/27/26 at 9:44 AM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the acting DON stated that Resident # 74's family member had made (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>arrangements for Resident #74 to see a dentist this coming March and that appointment was noted in the orders. The surveyor asked when the appointment was made. The acting DON stated that when the family member was made aware of the dental pain during the last care meeting he/she made the appointment. The surveyor reviewed the concern that Resident #74 had been noted to have dental concerns with repeated recommendations for a dental consult for 2 months before any appointments had been arranged.</p> <p>2) On 02/24/2026 at 9:21 AM, Resident #90 stated, I need dentures and the facility hasn't followed up.</p> <p>On 02/27/2026 at 11:47 AM, the surveyor requested dental assessments for Resident #90. The acting Director of Nursing stated that Resident #90 would be seen by dentist on their next visit to the facility. The surveyor requested information about prior dental visits and assessments.</p> <p>The record review on 02/27/2026 12:03 PM of Annual MDS assessments dated 10/16/24 and 10/18/2025 revealed that Section L read: Obvious or likely cavity or broken natural teeth on both assessments. The Annual MDS from admission dated 10/19/2023 did not indicate any dental concerns. The surveyor requested any documentation showing that any dental care was provided based on the assessments from the Administrator and the Regional Director of Clinical Operations.</p> <p>On 02/27/2026 at 12:50 PM the Administrator reported that she was unable to find any follow up dental care after the MDS assessments were made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, record review, and interviews, it was determined that the facility failed to ensure that residents were served a meals according to a predetermined menu and their preferences. This was found to be evident for 3 (#3, #5, and #90) out of 8 resident's meals that were observed for correctness during the recertification survey.</p> <p>The findings include:</p> <p>During an interview on 02/24/2026 at 9:15 AM, Resident #99 stated, They don't give me the food that is on the menu. This morning I was supposed to get sausage gravy on biscuits and I got scrambled eggs with dry toast. The surveyor observed that the meal ticket read sausage gravy with biscuits.</p> <p>On 02/24/2026 at 10:04 AM Resident #5 stated, I don't get what I am supposed to on my tray. Although the meal ticket read sausage gravy and biscuits and cottage cheese, the tray contained 2 boiled eggs and toast. Resident #5 further stated, I am supposed to have cottage cheese with all my meals but I never get it.</p> <p>On 02/26/2026 at 8:37 AM, an observation of Resident #2's breakfast tray did not include the alternative breakfast meats as stated on the meal ticket. Resident #2 stated that they received items not listed on their meal ticket and items listed in their dislikes section. GNA #18 entered the room and stated the kitchen does not update the tickets when they are out of foods. Residents often get foods listed in their dislikes. I can ask for turkey bacon. Resident #2 requested bacon, even pork, if that was the only option.</p> <p>On 02/26/2026 at 8:44 AM, Resident #5 received oatmeal, that is listed in her dislikes list, and no cottage cheese.</p> <p>On 02/26/2026 at 8:46 AM saw GNA #18 returned to room with bacon. She stated the kitchen did not have alternative breakfast meat available that day.</p> <p>02/26/2026 9:28 AM the Regional Director of Clinical Operations acknowledged the concerns. He stated he did know why the meal tickets printed dislikes for the residents to receive and confirmed the facility would investigate the issue.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observations and interviews, it was determined that the facility failed to serve food at residents preferred temperature. This was found to be evident for 2 (#90, #91) out 8 residents interviewed for palatable food during the recertification survey. The findings include: On 02/24/2026 at 1:53 PM Residents #90 and #91 stated the facility food is served cold and staff is too busy to heat it up. On 02/26/2026 at 8:37 AM, GNA #18 was asked the procedure for reheating food. GNA #18 stated, We are not allowed to heat up food for residents. On 02/26/2026 at 9:30 AM, the acting Director of Nurses was asked the procedure for heating up residents food when they complain about cold trays. She responded that staff do not heat up resident trays, they are supposed to return the food to the kitchen for reheating. 02/27/2026 9:12 AM GNA #24 was asked what they do when a resident complains about cold food. GNA #25 stated, I go heat it up in the microwave in the break room because we don't have anywhere else to do it. During a meal observation on 02/26/2026 at 12:23 PM, Resident #91 stated, My food is ice cold and the facility won't heat my food. Resident #91 refused to call for assistance when encouraged. During an observation of trays being pass to residents on 02/27/2026 at 8:25 AM, the surveyor noted the door to the tray cart left open after a tray was removed from the cart. The surveyor asked how the facility keeps food from getting cold on 03/02/2026 at 7:34 AM, the Food Service Director stated, We notify staff when we deliver trays to the floor. Sometimes staff brings back food to warm or residents call us to bring hot food. We get a lot of complaints about cold food. We put the food on heated plates but one side of the plate warmer is broken. I put in a work order to have it repaired. On 03/02/2026 at 1:41 PM, the acting Director of Nursing and the Administrator acknowledged the concern about the food delivery temperatures, staff confusion about the reheating process, and the broken plate warmer. They stated education would be provided and the warmer would be repaired. 02/26/2026 9:28 AM the RDCO stated he was not sure what the policy was for reheating food and he would follow up on it.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>Based on observation and record review, it was determined that the facility failed to provide assistive devices for meals to a resident. This was found to be evident for 1 (#14) out of 2 residents reviewed for assistive devices during the recertification survey. The findings include: On 02/26/2026 at 8:35 AM, the surveyor observed Resident #14 eating breakfast with a fork. The resident's hands visibly shook, causing food to fall from the fork as the resident tried to eat. On 02/26/2026 at 1:02 PM the surveyor observed Resident #14 eating breakfast using a fork. Resident #14's hands visibly shook, causing food to fall from the fork. When the surveyor asked the resident if the facility provided assistive utensils, Resident #14 shook their head no. The record review on 02/26/2026 at 1:10 PM revealed an order dated 10/28/2025 that read: Patient to use weighted spoon and fork during meals. The care plan dated 10/29/25 read, divided plate for meals, sippy cup and built up spoon. On 02/27/2026 at 7:34 AM, GNA #18 stated, If a resident needed assistive devices and staff did not find them on the tray, they will go to the kitchen to try and find them. We find out if they need it in the computer. On 02/27/2026 at 7:53 AM kitchen interview with the Food Service Director stated the process for assistive devices is that the meal ticket indicates the need, and the staff puts them on the tray. The surveyor then observed staff getting assistive devices from dish room. The Administrator and DON acknowledged the concern about the missing assistive devices during the interview at 8:19 AM on 02/27/2026.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure sanitary and safe food handling practices were followed to reduce the risk of foodborne illness. This was found to be evident in the refrigerators, freezer and storage areas observed during the recertification survey. The findings include: On 02/24/2026 at 7:55 AM, a tour of the kitchen was conducted with the Food Service Director (FSD). In the refrigerator, 3 sandwiches were on a shelf dated 2/20/24. They were discarded by the FSD. Spices in the cooking area lacked labels or dates. The FSD stated that staff should label them with the date opened. The walk in freezer had an unlabeled bag of green beans and a box of hash browns with a large ice formation on top almost covering the box. Icicles hung from the compressor above the box. The FSD stated they would discard the food and request a repair. The walk in refrigerator had ham dated 2/16/26, use by 3/2/26. The FSD stated it should be discarded after 7 days. On 02/27/2026 at 8:00 AM, the Administrator acknowledged the kitchen concerns and stated the compressor repairs would be addressed that day.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that a resident's medical record document was accurately completed. This was evident for 1 (Resident #10) of 2 residents reviewed for Preadmission Screening and Resident Review (PASARR).The findings include:Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Everyone who applies for admission to a nursing facility must be screened for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions.On 02/24/2026 at 11:37 AM, review of Resident #10's medical record revealed a PASARR document dated 2/11/25 which indicated the resident needed a level II screening.At the same time, further review of the Resident's medical record failed to reveal indication of a level II PASARR or that a level II was determined to not be required. On 02/25/2026 at 10:15 AM, an interview with the Director of Social Services (Staff #14) revealed that if a level I PASARR was filled out in a way that indicated a need for a level II screen, the facility would reach out to AERS (a mandatory federal program so that people with certain mental health conditions are not inappropriately placed into nursing homes).At the same time, further interview with Staff #14 revealed that AERS would determine if a level II screen was needed based on how the level I was filled out. The surveyor requested documentation of whether AERS indicated a level II screen was needed for the resident. On 02/26/2026 at 8:36 AM, a follow up interview with Staff #14 indicated he was unable to find any indication that AERS was informed regarding the level I screen nor if a level II was needed from AERS. At the same time, Staff #14 indicated that the level I screen was filled out incorrectly on section C question 2, and that he would have to complete a new one and resubmit it. The surveyor reviewed the concern. On 02/26/2026 at approximately 11:45 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview, it was determined that the facility failed to ensure linens were stored to maintain infection prevention. This was evident for 4 of 4 hallways observed during the annual survey. The findings include: 1a) On 02/26/2026 at 6:00 AM, an observation of the 500 hallway revealed a linen cart, which on the bottom shelf revealed a seat cushion that was visibly dirty, a wheelchair detachable leg/foot rest, a reusable bed pad, trash bags, and a brief (incontinence underwear). On 02/26/2026 at 8:05 AM, another observation of the 500 hallway revealed the same linen cart with the same items on it. On 02/26/2026 at 8:12 AM, an interview with the Director of Nursing revealed that the expectation for the linen carts on the hallways should only contain linen, to maintain infection prevention. The surveyor noted the linen carts with items on them noted above and requested a dual observation of the 500 hallway linen cart and other (100, 200, and 300) hallways. On 02/26/2026 at 8:14 AM, during the dual observation of the linen carts on each hallway revealed: The 500 hallway linen cart was in the condition as it was noted above. The 100 hallway linen cart on the bottom shelf had an opened size large gloves box, resident care items (cleanser and lotion), approximately 4 briefs, trash bags, a stack of plastic cups, two packs of adult wash cloths (one of which looked visibly opened and used), a packet of ointment, and a sheet of paper. The 300 hallway linen cart on the bottom shelf had 4 basins (a bucket like item used for bed baths) which had various items in them such as plastic cups with lids and straws, zinc oxide paste (skin protection paste), briefs, and toothbrushes. The 200 hallway linen cart on the top shelf had briefs. On 02/26/2026 8:21 AM, an interview with the Director of Nursing revealed that the items found on the linen carts during the dual observation should not be kept on the linen carts, and that there should only be clean linen on the carts. 1b) On 03/02/2026 at 7:12 AM, an observation on the 300 hallway revealed the clean linen cart had the front cover up on top of the linen cart, exposing the front of the cart and all of the clean linen stored inside. On 03/02/2026 at 7:13 AM, the surveyor requested dual observation with the Director of Nursing. During the dual observation, she indicated that the front cover on the linen cart should be down at all times unless someone is getting linen out from it, but then it should be put back down to protect the clean linen. On 03/02/2026 at 10:23 AM, a follow up observation on the 300 hallway revealed the clean linen cart had the front cover on top of the linen cart, exposing the front of the cart and all of the clean linen stored inside. On 03/02/2026 at 10:23 AM, the surveyor observed Geriatric Nursing Assistant (Staff #43) walk by the linen cart and pull down the front cover. At the same time, an interview with Staff #43 revealed that the front cover of the linen cart should be down and covering the clean linen at all times. On 03/03/2026 at approximately 1:05 PM, the concern was reviewed with the Director of Nursing and the Nursing Home Administrator during the exit conference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation and staff interview, it was determined the facility failed to keep equipment in the kitchen in safe, operating condition. This was found to be evident for the walk-in freezer, plate warmer, and the hot water heater during the kitchen tours. The findings include: The surveyor conducted a kitchen tour with the Food Service Director (FSD) on 02/24/2026 at 7:55 AM. Inside the walk-in freezer, the surveyor observed a large ice formation on top of a box of hash browns, almost covering it. Icicles also hung from the compressor above the box. The FSD stated a request for repair would be submitted. On 02/26/2026 at 7:05 AM, the Maintenance Director stated that the compressor in the walk in freezer compressor needed charging and might be serviced that day. On 02/27/2026 8:00 AM the Administrator stated they are working on the compressor today. On 3/2/2026 at 7:30 AM, the surveyor observed the walk-in freezer still showed small drips on the compressor. The FSD stated a plan to have maintenance evaluate the freezer. At 7:34 AM, when the surveyor asked the FSD about food temperatures, the FSD stated, We get a lot of complaints about cold food. We put the food on hot plates but one side is broken. I put in a work order to have it repaired. On 03/02/2026 at 1:41 PM, the Administrator acknowledged the concern about the the broken plate warmer. The Administrator stated the broken plate warmer would be repaired. The surveyor attempted to observe the dishwashing process on 03/03/2026 at 9:08 AM. Dietary Aid #39 informed the surveyor that the hot water heater was broken and they were unable to safely wash the dishes. The facility had a service call out for repairs. On 03/03/2026 at 9:26 AM the Maintenance Director stated the process would not work until the hot water returned. On 03/03/2026 at 9:32 AM the Administrator stated the use of paper products and a plan to wash dishes once the hot water returned. The Administrator also stated the facility called for emergency repairs. A dish machine observation with the Administrator on 03/03/2026 at 11:03 AM, showed wash temperatures at 142 and rinse temperatures at 186. The Administrator stated a plan to call Ecolab if temperatures and sanitizer levels were not correct after the hot water heater was fixed. The Administrator also stated staff would reprocess all the dishes after validating the equipment worked. At 11:10 AM, the surveyor showed the Administrator water dripping onto an open food box under the compressor in the walk-in freezer. The Administrator stated the intention to discard the food and call for service again.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observations and interviews it was determined the facility failed to ensure that the resident's call system was functioning properly. This was found to be evident for 1 of 3 units observed during the survey. The findings include: On 2/24/26 at 10:35 AM, the surveyor observed the call light in nurses' station #3 continuously beeping however no call lights were going off in the hallway nor room numbers showing up on the screen. The surveyor asked Registered Nurse (RN) #6, who was in the nurses' station, why the call light was beeping every 3 seconds. RN #6 stated it had been like that for a while. She further stated maintenance had looked at it but was not able to fix it. RN #6 confirmed that when a resident called the room number would show up on the screen, but the beeping was continuous. On 2/26/26 at 7:43 AM, the surveyor conducted an interview with the Maintenance Director Staff #17. During the interview Staff #17 stated that he was unaware that the call system was not working properly at nurses' station #3. The surveyor and Staff #17 walked to the nurses' station and again the call system was beeping every three seconds even though no resident was calling. Staff #17 confirmed that the call systems in other nurses' stations were not like this and did not have a continuous beep. He stated he would look into the issue. On 2/26/26 at 1:43 PM, the surveyor reviewed the concern with the Nursing Home Administrator (NHA) about the call system that was not working properly in nurses' station #3. The NHA stated she was aware of the issue and that maintenance was working on fixing the issue.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received training on abuse, neglect, and exploitation. This deficient practice was evident for 2 of 6 employee files reviewed during the annual survey. The findings include: On 02/27/26 at 7:51 AM, during an interview with the Director of Nursing (DON), the DON reported that nursing skills competencies are verified at the time of orientation and reassessed annually. The DON further explained that the facility utilizes a learning platform called Relias to complete required monthly and annual training. On 03/02/2026, the surveyor reviewed the facility assessment which was most recently approved in January 2026. Review of the section related to staff training, education, and competencies identified training requirements for staff including abuse, neglect and exploitation, infection control, dementia management, quality assurance and performance improvement, compliance & ethics. On 03/02/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #36 and Licensed Practical Nurse (LPN) # 38 employee files failed to show evidence of abuse training. On 03/03/2026 at 9:42 AM, the surveyor followed up with the DON regarding the missing 2025 annual abuse, neglect, and exploitation training for GNA #36 and LPN #38. The DON acknowledged that the required annual training for these staff members was not completed in 2025.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>*Based on administrative record review and staff interviews, it was determined that the facility failed to ensure staff received training on Quality Assurance and Performance Improvement (QAPI). This deficient practice was evident for 3 of 6 employee files reviewed during the annual survey. The findings include: On 02/27/26 at 7:51 AM, during an interview with the Director of Nursing (DON), the DON reported that nursing skills competencies are verified at the time of orientation and reassessed annually. The DON further explained that the facility utilizes a learning platform called Relias to complete required monthly and annual training. On 03/02/2026, the surveyor reviewed the facility assessment which was most recently approved in January 2026. Review of the section related to staff training, education, and competencies identified training requirements for staff including abuse, neglect and exploitation, infection control, dementia management, quality assurance and performance improvement, compliance & ethics. On 03/02/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #36, GNA #37 and Licensed Practical Nurse (LPN) # 38 employee files failed to show evidence of QAPI training. On 03/03/2026 at 9:42 AM, the surveyor followed up with the DON regarding the missing 2025 QAPI training for GNA #36, GNA #37 and LPN #38. The DON acknowledged that the required annual training for these staff members was not completed in 2025.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received infection control training. This deficient practice was evident for 3 of 6 employee files reviewed during the annual survey. The findings include: On 02/27/26 at 7:51 AM, during an interview with the Director of Nursing (DON), the DON reported that nursing skills competencies are verified at the time of orientation and reassessed annually. The DON further explained that the facility utilizes a learning platform called Relias to complete required monthly and annual training. On 03/02/2026, the surveyor reviewed the facility assessment which was most recently approved in January 2026. Review of the section related to staff training, education, and competencies identified training requirements for staff including abuse, neglect and exploitation, infection control, dementia management, quality assurance and performance improvement, compliance & ethics. On 03/02/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #36, GNA #37 and Licensed Practical Nurse (LPN) # 38 employee files failed to show evidence of infection control training. On 03/03/2026 at 9:42 AM, the surveyor followed up with the DON regarding the missing 2025 infection control training for GNA #36, GNA #37 and LPN #38. The DON acknowledged that the required annual training for these staff members was not completed in 2025.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Snf LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide training in compliance and ethics.</p> <p>Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received compliance & ethics training. This deficient practice was evident for 3 of 6 employee files reviewed during the annual survey. The findings include: On 02/27/26 at 7:51 AM, during an interview with the Director of Nursing (DON), the DON reported that nursing skills competencies are verified at the time of orientation and reassessed annually. The DON further explained that the facility utilizes a learning platform called Relias to complete required monthly and annual training. On 03/02/2026, the surveyor reviewed the facility assessment which was most recently approved in January 2026. Review of the section related to staff training, education, and competencies identified training requirements for staff including abuse, neglect and exploitation, infection control, dementia management, quality assurance and performance improvement, compliance & ethics. On 03/02/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #36, GNA #37 and Licensed Practical Nurse (LPN) # 38 employee files failed to show evidence of compliance & ethics training. On 03/03/2026 at 9:42 AM, the surveyor followed up with the DON regarding the missing 2025 compliance & ethics training for GNA #36, GNA #37 and LPN #38. The DON acknowledged that the required annual training for these staff members was not completed in 2025.</p>		