STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215232	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Nursing & Rehabilitation Center	706 East Alder Street Oakland, MD 21550

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observation, interview, facility document review, and facility policy, the facility failed to protect residents from verbal and physical abuse for 2 (Resident #4 and Resident #5) of 7 residents reviewed for abuse. Findings included:A facility policy titled, Abuse, Neglect, Exploitation, or mistreatment, dated 10/23/2019, indicated, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately. 1. A Face Sheet revealed the facility admitted Resident #5 on 08/23/2024. According to the Face Sheet, the resident had a medical history that included an injury to the lumbar spine, anemia, insomnia, and coronary artery disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had no behaviors and was independent with sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transferring, and toilet transfers. The resident did not have any pressure ulcers or any skin conditions, and Resident #5 was receiving an anticoagulant. Resident #5's Care Plan included a problem statement initiated on 08/26/2024 that indicated the resident had socially inappropriate/disruptive behavioral symptoms and accusatory statements as evidenced by calling the police related to staff taking the remote, accusing staff and residents of multiple things like stealing items (all had been found), and attention seeking. There were no approaches listed in meeting the goal of not exhibiting socially inappropriate/disruptive behaviors with accusatory statements. A Facility Reported Incident Initial Report Form, dated 01/30/2025, indicated the Director of Nursing (DON) was made aware of an allegation of verbal and physical abuse related to Resident #5. Geriatric Nursing Assistant (GNA) #7 was asked by the resident to move items from the resident's bedside table, and the GNA responded, No, you have hands, and then the GNA allegedly grabbed Resident #5's wrist. The allegation was reported to Licensed Practical Nurse (LPN) #15. The GNA was interviewed and suspended pending investigation, and the agency was notified. The Activities Director was named as a witness. A Facility Reported Incident Follow-Up Investigation Report form, undated, revealed Resident #5 was interviewed on 01/30/2025 at 2:00 PM by the DON and Assistant DON (ADON). The resident stated they had dishes on their bedside table and asked the aide to take them up front. Resident #5 stated the aide told them that they had hands, and then the aide grabbed ahold of both of the resident's wrists and squeezed them. A full body assessment was completed, with no alterations noted. An interview on 01/30/2025 at 1:50 PM with GNA #7 revealed the resident had put on their call light and asked for their table to be cleaned off. The GNA told Resident #5 they could do it themself and that the resident had two hands. The GNA then stated she told the resident to give her hands to the GNA, and the resident placed their hands in GNA #7's hands. The resident then pulled back the GNA's thumbs, and the GNA had to force the resident to let go. The GNA then walked away. GNA #7 stated she did not do anything out of line. The facility substantiated the allegation of verbal and physical abuse based on GNA #7 stating she had told the resident she had hands and could do this themself and the resident's hands were held by the GNA. The GNA was suspended, and the agency was notified. The GNA was reported to the Maryland Board of Nursing. Resident #5 was observed during the survey and was up in their wheelchair, dressed appropriately, talkative, and active throughout the day. During an interview on 07/21/2025 at 9:55 AM, Resident #5 stated the resident did not recall anyone speaking badly or abusing them. During a phone interview on 07/23/2025 at 11:59 AM, GNA #7 stated she had gone into the resident's room, and the resident wanted their bed made. The GNA stated she informed the resident she was taking care of another resident at the time and would return. GNA #7 then stated the resident grabbed her hand and bent her fingers back. She stated that was what she had told the nurse. She then stated she never told the resident they could do things for themself, and she would never have grabbed a resident's hands to make them do anything. During an interview on 07/23/2025 at 9:45 AM, LPN #15 stated she did not ask GNA #7 what happened, but the GNA came to her and told her what she did, taking the resident's hands and telling the resident they could clean their table. The GNA stated to LPN #15 they felt certain the resident would report them. LPN #15 then stated she immediately informed the DON. LPN #15 also stated GNA #7 told her that Resident #5 never wanted to do anything for themselves, and that was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility document review, staff interview, and facility policy review, the facility failed to submit an initial allegation of a bruise of unknown origin and failed to submit a five-day follow-up report of verbal abuse timely for Resident #5. Additionally, the facility failed to submit a five-day follow-up report of misappropriation of property timely for Resident #6. These failures affected 2 (Resident #5 and Resident #6) of 7 residents reviewed for abuse. Findings included:A facility policy titled, Abuse, Neglect, Exploitation, or mistreatment, dated 10/23/2019, indicated, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately. Component V: Reporting/Response: 1. All alleged violations concerning abuse, neglect, or misappropriation of property are reported verbally immediately to the Facility Abuse Coordinator, the Administrator and to other officials in accordance with state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities).1. A Face Sheet revealed the facility admitted Resident #5 on 08/23/2024. According to the Face Sheet, the resident had a medical history that included an injury to the lumbar spine, anemia, and coronary artery disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had no behaviors, used a wheelchair, and was independent with sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transferring, and toilet transfers. The resident did not have any pressure ulcers or any skin conditions, and Resident #5 was receiving an anticoagulant. A nursing Progress Note, dated 06/30/2024 at 1:05 AM, indicated Resident #5 was noted to have a large bruise on their inner left thigh, approximately two inches by two inches. The resident was unsure how or when they obtained the bruise. A nursing Progress Note, dated 06/30/2024 at 2:12 PM, indicated the Director of Nursing (DON) was made aware of a bruise to the inside of Resident #5's thigh. An initial report was submitted to the state survey agency on 06/30/2025 at 1:32 PM, which was not timely. A five-day follow-up report was submitted on 07/08/2025, which was timely. During a phone interview on 07/22/2025 at 8:01 PM, Registered Nurse (RN) #9 stated the nursing assistant noticed a bruise on the inner left thigh of the resident, and she was notified. RN #9 then stated she assessed the area, and the resident did not know when the bruise occurred or how they received the bruise. RN #9 then stated she had come from a hospital setting and although she had abuse training, she did not think to report it immediately and believed she had informed the oncoming nurse. During an interview on 07/29/2025 at 11:43 AM, the DON stated her expectation was for any injury of unknown origin to be reported immediately, primarily for the protection of the resident. The Administrator was interviewed on 07/31/2025 at 1:23 PM. The Administrator stated all reports of abuse should be completed and sent to the state within the appropriate timeframes.2. A Face Sheet revealed the facility admitted Resident #5 on 08/23/2024. According to the Face Sheet, the resident had a medical history that included an injury to the lumbar spine, anemia, and coronary artery disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had no behaviors, used a wheelchair, and was independent with eating, following set up/clean up, sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transferring, and toilet transfers. The resident did not have any pressure ulcers or any skin conditions, and Resident #5 was receiving an anticoagulant. A Facility Reported Incident Initial Report Form, dated 01/30/2025, indicated Resident #5 made an allegation of verbal abuse to Licensed Practical Nurse (LPN) #15 on 01/30/2025 at 1:45 PM. LPN #15 reported this to the Director of Nursing (DON) on 01/30/2025 at 1:45 PM. An initial report was submitted to the state survey agency on 01/30/2025, which was timely, and a five-day follow-up report showed no date/time of submission to the state survey agency. A Facility Reported Incident Follow-Up Investigation Report Form was undated/untimed. During an interview on 07/29/2025 at 11:43 AM, the DON stated her expectation was all allegations of abuse would be reported timely to the state agency. The Administrator was interviewed on 07/31/2025 at 1:23 PM. The Administrator stated all reports of abuse should be completed and sent to the state within the appropriate timeframes. 3. A Face Sheet revealed the facility admitted Resident #6 on 03/30/2010. According to the Face

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, interview, facility document review, and facility policy review, the facility failed to ensure an alarm on the fire exit door of the secured unit sounded to prevent elopement for 1 (Resident #7) of 1 resident reviewed for elopement. The failure resulted in Resident #7 exiting the facility on the morning of 07/28/2024 at 6:10 AM and being found by staff approximately one-half mile from the facility at approximately 7:00 AM. It was determined the facility's non-compliance with one or more requirements of participation had caused or was likely to cause serious injury, serious harm, serious impairment, or death to one or more facility residents. The Immediate Jeopardy (IJ) was related to 42 CFR 483.25(d), F689, Supervision to Prevent Accidents at a scope and severity of J. The IJ began on 07/28/2024 when Resident #7 exited the facility through the fire exit door on the secured unit. The survey team notified the Administrator of the IJ and provided the IJ template on 07/28/2025 at 12:15 PM. Beginning 07/28/2024 and continuing until 08/05/2024, the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past non-compliance was cited. The findings include:A Resident Face Sheet revealed that Resident #7 on 02/20/2024 had a medical history that included diagnoses of Parkinson's disease, schizoaffective disorder, and dementia. A quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 05/28/2024, revealed Resident #7 had a Brief Interview for Mental Status score of 6, which indicated the resident had severe cognitive impairment. Resident #7's Care Plan, revealed a problem statement with a start date of 02/23/2024 that indicated the resident was at risk for elopement and required the use of a wander guard. Interventions indicated the resident resided on the secure unit and directed staff to check the wander guard battery daily and check proper function of the wander guard every shift. Resident #7's Observation Detail List Report, dated 05/07/2024, revealed the resident was not alert and oriented to person, place and time, did not have safe decision-making capabilities, had a history of wandering, and had made no attempts to leave the facility. The report indicated the intervention was to have the resident reside on the secured unit and have a wander guard bracelet in place. A Progress Note, dated 07/28/2024 at 11:40 AM, revealed a geriatric nursing assistant was conducting rounds and noticed Resident #7 was not in their room. Per the Progress Note, a Code Pink was called and staff began looking in all rooms on all floors. Three staff members left the facility and drove around searching for the resident. According to the Progress Note, Resident #7 was located approximately one-half mile from the facility at approximately 7:00 AM and returned to the facility at 7:10 AM. The Progress Note revealed an assessment was completed and identified minor scrapes to the resident's left lower extremity from tall grass but indicated the resident had no complaints of discomfort. Review of the Facility Reported Incident Follow-Up Investigation Report Form, revealed Licensed Practical Nurse (LPN) #4 had last seen Resident #7 ambulating on the unit and had redirected the resident back to their room. During an interview on 07/22/2025 at 12:19 PM, Registered Nurse (RN) #6 stated she arrived for her shift on 07/28/2024 just after 6:00 AM and was informed Resident #7 was missing. She stated management and law enforcement had been notified, and a search began inside and expanded outside the facility. Per RN #6, Resident #7 was brought back to the facility just after 7:00 AM by staff. She stated the resident was assessed and had minor scratches to the left lower extremity. The resident was dressed for the day and wearing shoes, but no socks. She stated Resident #7 ambulated independently and resided on the secure unit and, at the time of the incident, the alarm on the exit door did not sound. During an interview on 07/22/2025 at 12:30 PM, the Administrator stated the fire exit door located at the end of the secure unit had an alarm; however, the toggle switch to the alarm was turned off while a family moved furniture into the unit. He stated that the toggle switch did not get turned back on; therefore, there was no electrical supply to the door and the alarm did not sound when Resident #7 exited the door. The Administrator stated no additional residents exited the facility during the time the alarm was not functioning. During a follow-up interview on 07/22/2025 at 1:47 PM, the Administrator stated the door Resident #7 exited was a fire door and was not equipped with a wander guard sensor. He confirmed that when the toggle switch for the door alarm was turned off, the alarm was non-functional because the electricity had been shut off; therefore, when the alarm was turned off, it would not sound when the door was opened. During a phone interview on 07/24/2025 at 11:18 AM, the Medical Director stated he was made aware of Resident #7's elopement and that the facility met regarding a mitigation plan. The Medical Director stated Resident #7 exhibited wandering behavior and had a wander guard, but unfortunately, left the facility through an exit door. Per the Medical Director, the resident was found nearby by a staff member, and as the Medical Director

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to monitor and assess a resident's oral fluid intake, notify the physician of changes in intake, and put interventions in place to maintain adequate hydration for 1 (Resident #3) of 3 residents reviewed for dehydration. Specifically, the facility failed to identify and address Resident #3's inadequate fluid intake, which resulted in actual harm to Resident #3 who required hospitalization with diagnoses of encephalopathy and dehydration.The findings include:A facility policy titled, Hydration - Oral, dated 05/05/2023, indicated, 1. Recommend fluids (6-8 glasses per day) to patients/residents during and in-between meals and during periods of physical activity. The policy also specified, 3. Closely monitor all patients/residents at risk for dehydration, who have a history of poor oral intake and are enterally fed (NPO) [nothing by mouth] or have an indwelling catheter. I & O [Intake and Output] is recorded when indicated. A Resident Face Sheet revealed Resident #3 had a medical history that included diagnoses of cerebral infarction due to an unspecified occlusion or stenosis of the right middle cerebral artery, diabetes mellitus, dementia, dysphagia, and nutritional deficiency. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2023, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required set-up or clean-up assistance from staff for eating. The MDS indicated the resident had no vomiting, fever, or dehydration and no signs/symptoms of swallowing disorders during the look-back period. The MDS revealed Resident #3 was 65 inches in height, weighed 141 pounds, and received a therapeutic diet. Resident #3's Care Plan, included a problem statement, dated as initiated 01/15/2020, for dehydration/fluid maintenance that indicated the resident was at risk for dehydration related to cerebrovascular accident and diabetes mellitus. Interventions directed staff to assess for dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance), assess risk factors for dehydration, assist with fluids as needed, encourage fluids throughout the day, keep fluids accessible, monitor laboratory work as ordered, and record intake and output every shift. A Dehydration Risk Evaluation and Care Planning Worksheet, dated 09/05/2023, indicated Resident #3 had the following risk factors: urinary incontinence, limited range of motion, used laxatives and anti-depressants, had depression/mood disorders, cerebrovascular accident, diabetes mellitus, and dysphagia. Potential interventions included: adaptive devices to assist with fluid consumption, encourage oral rehydration, offer fluids between meals and with medications, assist with fluids and meals, and monitor labs. Resident #3's Observation Detail List Report, revealed a dietary note dated 11/28/2023 at 11:48 AM, that indicated the resident's estimated fluid needs at their current weight was 1991 milliliters (ml) of fluid per day. The report indicated the resident's documented fluid intake ranged from [PHONE NUMBER] ml, with an average documented fluid intake of 1468 ml (which would represent a 523 ml per day fluid deficit). A document titled, Message History for Resident #3, revealed the resident consumed less than 1200 ml of fluid on the following dates: 01/07/2024, 01/08/2024, 01/10/2024, 01/11/2024, 01/13/2024, 01/17/2024, 01/18/2024, and 01/20/2024. Resident #3's Progress Notes, for the timeframe from 01/03/2024 through 01/19/2024, lacked evidence of any assessments of the resident's oral intake, symptoms of dehydration, or interventions to increase fluid intake. Resident #3's Progress Note, dated 01/20/2024 at 6:14 PM, indicated the resident looked pale and lethargic. Per the Progress Note, the resident was leaning more to their left side, and their hand grasps were weak on the left side. The physician was notified, and the resident was sent to the hospital for evaluation. Resident #3's Progress Note, dated 01/21/2024 at 10:43 AM, indicated the resident was admitted to a local hospital with a diagnosis of metabolic encephalopathy. The hospital admission H&P [History and Physical], dated 01/20/2024, indicated Resident #3 was seen for altered mental status. The resident presented to the emergency room hypotensive and visibly very dry. Per the H&P, the workup showed an acute kidney injury. The physical examination revealed an ill-appearing individual, cachectic (a complex condition characterized by weight loss and muscle wasting), with an unkempt appearance, dry mucous membranes, and dry mouth and tongue with cracked mucous membranes. The H&P indicated that the resident's skin was dry and pale and their laboratory results revealed a blood urea nitrogen (BUN) level of 46, with the normal range being 8 to 25 (BUN levels measure the amount of urea nitrogen in the blood, which helps assess kidney function). The assessment section

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and policy review, the facility failed to check the automated external defibrillator (AED) daily for 157 days out of 421 days (37%). Findings included:Review of the manufacturer's Periodic Maintenance insert, undated, revealed the AED should be checked to ensure the Rescue [NAME] indicator is green, the battery had charge, the prompts were working on the LED (light emitting diode), the display was readable, the pads were ready for use, all buttons were working, and the case was intact. Review of the AED checks from 06/2024 until 07/25/2025 revealed 157 days out of 421 days went unchecked. During a phone interview on 07/26/2025 at 1:58 PM, Licensed Practical Nurse #18 stated her normally scheduled shift was 6:30 AM and it was the responsibility of the nurse working on Level 1 to do the crash cart on that level and the crash cart and AED on Level 3/2 when coming in for their shift. During a phone interview on 07/28/2025 at 4:07 PM, Registered Nurse (RN) #21 stated she worked the evening shift and it was not her responsibility to check the crash carts. During an interview on 07/25/2025 at 12:15 PM, the Director of Nursing stated she expected checks to be completed daily on the crash cart and the AED. She stated the facility did not have a specific policy, only the manufacturer's instructions for periodic maintenance. The Administrator was interviewed on 07/31/2025 at 1:38 PM. The Administrator stated he expected the AED equipment and crash carts to be checked daily to ensure all equipment was functioning and stocked.