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	12/12/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, observations, and record review, it was determined that the facility failed to manage Residents' pain. This was evident for 2 (Residents #6, #59) of 2 residents reviewed for pain management. The findings include: The PAINAD (Pain Assessment in Advanced Dementia) Scale is a tool that assesses pain levels in patients with cognitive impairments, such as delirium or dementia, by observing the patient for five minutes and then scoring behaviors such as breathing, independent of vocalization, negative vocalization (like occasional moaning or groaning, or repeated troubled calling out), facial expression, body language, and consolability.Proper use of the PAINAD Scale, as part of a comprehensive pain management plan, can help reduce the likelihood of a patient experiencing unrecognized and untreated pain. The total score ranges from 0 to 10. A possible interpretation of the scores is: 1-3=mild pain, 4-6=moderate pain, 7-10=severe pain.1) During an interview on 12/8/2025 at 11:47 AM, Resident #6's representative reported that Resident #6's leg pain was poorly managed.During multiple observations in the survey, Resident #6 was observed yelling unintelligible words.A review of Resident #6's medical record included hospital records indicating that Resident #6 had significant end-stage dementia and severely impaired cognition, and that the resident's legs are chronically extended with feet pointed.Further review included an admission assessment for Resident #6. The evaluation recorded under Resident history that Resident #6 had chronic pain. Continued review included a pain care plan for Resident #6, initiated on 6/4/25 and revised on 11/25/25, which stated that s/he was at risk for pain due to recent surgery. The care plan goal stated that [Resident #6] is cognitively impaired. Specific Behaviors that may indicate the resident is experiencing pain will be identified and lessened. The interventions on the care plan stated that Residents who are cognitively impaired and unable to verbally express pain will be observed utilizing the recommended pain evaluation (PAINAD).A review of Resident #6's current provider's orders as of 12/10/25 included an order initiated on 7/29/25 for staff to Check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale (M)Mild, (Mo)Moderate, (S)Severe, (VS)Very Severe.Further review of Resident #6's Medication Administration Record (MAR) for August 1 to October 31, 2025, revealed that staff assessed Resident #6 to have pain on: 8/7/25 (pain scale of 8), 8/12/25 (pain scale of 3), 8/27/25 (pain scale of 5), 9/8/25 (pain scale of 1), 9/18/25 (pain scale of 4), 9/22/25 (pain scale of 3), 9/28/25 (pain scale of 3), 10/13/25 (pain scale of 4), and 10/20/25 (pain scale of 2).However, the review failed to demonstrate that the staff managed Resident #6's pain to the identified levels on those days. In an interview on 12/11/2025 at 4:10 PM, the director of nursing reviewed Resident #6's record and confirmed that it lacked documentation of staff managing Resident #6's pain on 8/7/25 at a level of 8, 8/12/25 at a level of 3, 8/27/25 at a level of 5, 9/8/25 at a level of 1, 9/18/25 at a level of 4, 9/22/25 at a level of 3, 9/28/25 at a level of 3, 10/13/25 at a level of 4, and 10/20/25 at a level of 2.2) A review of incident #2594490 showed that Resident #59 fell, was noted to be limping, and was sent to the emergency room for evaluation.Further review of the facility's investigation of the incident included an SBAR (Situation, Background, Assessment, and Recommendation) Communication Form for Resident #59. The document noted that after the fall, The resident had scattered bruises to the [bilateral upper extremities] and redness in the right hip/buttocks area. The resident stood up without difficulty; however, once [s/he] began ambulating, [s/he] started limping. The resident was laid down immediately. The nurse then reassessed [range of motion], and the resident reported that [his/her] right hip was hurting on the inside and was unable to rate his pain; guarding was noted at times.The review showed that Resident #59 was sent to the hospital for further evaluation; however, it did not demonstrate that the resident's pain was managed before hospitalization.Further review of the hospital records showed that Resident #59 had a right pelvic fracture.During an interview on 12/12/2025 at 12:02 PM, the DON reported that she expected staff to manage Resident #59's pain before the resident was sent to the hospital. However, after reviewing Resident #59's medical record, she noted that there was no documentation of the resident's pain being managed before the hospital transfer.