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

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, it was determined that the facility failed to ensure that licensed nurses had specific competencies and skill sets necessary to care for residents' needs. This was evident for 5 (Staff #12, #13, #14, #15, and #16) of 5 randomly selected Licensed Practical Nurses (LPNs) during the Staffing task portion of the annual survey.The findings include:On 12/09/25 skills and competency evaluations were requested for 5 randomly selected LPNs: Staff #12, Staff #13, Staff #14, Staff #15, and Staff #16.On 12/11/25 at approximately 11:00 AM, an interview was conducted with the Director of Nursing (DON) to again request skills and competency evaluations since none had yet been provided. The DON said that there were no skills or competencies for any of the 5 LPNs (Staff #12, Staff #13, Staff #14, or Staff #15), and explained that no skills competencies had been done.No further evidence was provided by the end of the survey.

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

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, it was determined that the facility failed to ensure there was a Registered Nurse (RN) for at least 8 consecutive hours every day. This was evident for 2 days (11/23/25, 12/03/25) of 22 days reviewed for federal staffing compliance during the annual survey.The findings include:On 12/08/25 at approximately 8:20 AM, during the entrance conference, nursing staffing schedules were requested for 12/08/25 through 12/21/25. They were provided at 10:59 AM. A review revealed that some days lacked any scheduled RN. In an interview with the Director of Nursing (DON), she explained that there was at least one RN scheduled for each weekend shift and during the week there were administrative RNs such as herself, the MDS nurse, and the IP nurse on duty in the building. When asked she said she was the supervisor on weekends but was on call and did not come to the facility on weekends. She further explained that all licensed nurses worked 12-hour shifts. She further explained that the facility had a staff scheduler, but she just started 5 days ago.On 12/11/25 at 1:32 PM the DON was asked to provide the schedule and actual staff assignments and daily census for 11/16/25 through 12/07/25 to verify that each day had an RN working for at least 8 hours. The DON immediately provided a binder of daily staffing meetings, which listed the predicted scheduled hours on the front and had handwritten nurse and Geriatric Nursing Assistants (GNA) unit assignments on the back of each sheet.On 12/11/25 at 1:58 PM the requested unit assignment sheets for the period of 11/16/25 through 12/07/25 were provided and reviewed. The review revealed that on Sunday 11/23/25 and Sunday 12/07/25 no RNs worked any part of each day.On 12/12/25 at 11:50 AM an interview was conducted with the DON to review that the facility failed to have an RN work any part of 11/23/25 or 12/07/25. The DON confirmed the deficiency.No further evidence was provided by the end of the survey.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, it was determined that the facility failed to ensure that the Quality Assurance and Performance Improvement (QAPI) committee maintained a comprehensive, data-driven program. This failure was evident for one of one QAPI program reviewed during the Quality Assurance task.The findings include:The QAPI program, as mandated by the Centers for Medicare & Medicaid Services (CMS) for long-term care facilities, is a comprehensive, data-driven, and systematic approach to continually improving the safety, quality of life, and quality of care for residents.The QAPI plan is a formal, high-level, document that serves as the blueprint for the facility's QAPI program, outlining the facility's goals and systematic approach to identifying, addressing, and monitoring quality deficiencies.In contrast, QAPI policies and procedures provide detailed instructions specifying how, when, and by whom tasks related to the QAPI plan are carried out, translating the plan's broad vision into actionable, repeatable workflows for staff.On 12/8/25 at 8:16 AM, the surveyor conducted an entrance conference with facility leadership and requested the facility QAPI plan to be provided within four hours. By approximately 11:30 AM, it had not yet been provided. Once notified, the Clinical Services Director promptly submitted the available materials. Upon review, the surveyor found several Leadership Policies and Procedures for the QAPI program but could not locate the QAPI plan. When asked to provide the plan, the Nursing Home Administrator (NHA) sought clarification regarding what specifically was being requested, indicating uncertainty about the distinction between the QAPI policies and the formal QAPI plan. He stated he would work on getting it.On 12/9/25, the surveyor followed up, and the NHA indicated he was still looking for it. On 12/10/25 at 9:46 AM, the surveyor reviewed the facility's Leadership Policies and Procedures for QAPI, which outlined responsibilities including collecting, analyzing, tracking, and trending data to identify quality deficiencies, prioritizing high-risk or problem-prone areas, implementing corrective actions, conducting root cause analyses, and reporting monthly consolidated data to the Executive Board.On 12/11/25 at 2:03 PM, the NHA confirmed he is the head of the QAPI committee but was still unable to provide the QAPI plan.On 12/12/25 at 12:02 PM, the surveyor interviewed the Nursing Home Administrator (NHA), who confirmed that he serves as the chair of the QAPI committee and is responsible for oversight of the QAPI program. When asked to describe the facility's QAPI process, he stated that the committee holds meetings with appropriate personnel to discuss important topics. He explained that topics are identified based on issues previously discussed, items that arise during morning or afternoon meetings, or concerns brought to leadership's attention. When asked to provide an example, he identified hydration, stating that the issue was identified by surveyors during the October 2025 complaint survey.The surveyor asked the NHA to explain the hydration issue, what the audit data showed, and how the information was used to guide actions. The NHA provided audit documentation related to hydration; however, he was unable to explain how the data had been analyzed, what conclusions were reached, or what actions resulted from the findings, stating, we just talk about it. He confirmed that the facility does not maintain data, benchmarks, or trend analysis and has not conducted any required Performance Improvement Projects (PIPs). When asked how deviations from expected performance or negative trends are identified, he stated that an audit may identify an issue or something that has come up during a meeting.When asked to provide evidence of audits conducted over the past year, the NHA was unable to provide any audit tools or documentation other than those completed after the October 2025 complaint survey. He confirmed there was no additional evidence of audits, data tracking, or performance monitoring for the prior year.When asked how staff report quality concerns, the NHA stated that staff are instructed to report concerns to the charge nurse, Director of Nursing (DON), Assistant DON, or the NHA. When asked how QAPI priorities are determined, he stated that the DON and NHA discuss issues prior to meetings and that sometimes other committee members' concerns are considered. When asked how the facility determines whether (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	corrective actions have been implemented, are effective, or improvements are sustained, he repeatedly stated, we talk about it, and confirmed that the facility does not track trends or maintain a formal system to monitor the effectiveness of interventions.When asked to provide examples of audits conducted since the October complaint survey, the NHA identified audits related to hydration and daily review of self-reports and provided the audit tools; however, he was unable to explain how the results were analyzed or used to drive performance improvement. He further stated that the facility does not track or analyze adverse events or medical errors and does not use such information to implement preventive actions (they just talk about it). When asked about current QAPI objectives, he identified the same issues cited by surveyors during the October complaint survey.The NHA then provided a document titled QAPI Overview, which he identified as the facility's QAPI plan. The document listed focus areas including concerns identified during the October complaint survey, nutrition and hydration, abuse and neglect, monitoring of AEDs, and nursing education. The NHA confirmed that these items originated from the facility's plan of correction and stated that audits had been completed for each area; however, he was unable to provide evidence demonstrating how audit data was analyzed, trended, or used to monitor the effectiveness of corrective actions. When asked if the facility uses a template or system to track audit data, he stated, No, but the DON might.On 12/12/25 at approximately 12:50 PM, the surveyor interviewed the DON, who provided a QAPI program outline emphasizing a data-driven approach and outlining department responsibilities and chartered performance improvement projects. The DON stated they had conducted a Falls PIP but was unsure if the data was tracked and indicated that the NHA should be aware, as he attends the meetings. She further stated that she was not aware the facility was expected to systematically track and analyze data as part of the QAPI program but stated they do take meeting notes. At exit, the facility was unable to provide any data-driven evidence from QAPI meetings, demonstrating a failure to maintain a comprehensive, systematic, and evidence-based QAPI program.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record review, it was determined that the facility failed to maintain sidewalks and patios in a manner that was safe for residents, staff, and the public. This failure was evident for three of three sidewalks observed and one of one patio observed during the Environmental task.The findings include:On 12/08/25 at approximately 4:15 PM, a surveyor was walking along an upper sidewalk leading to the parking lot when the wheels of the surveyor's roller bag caught in a hole in the sidewalk, causing the bag to abruptly lodge and pull from the surveyor's hands.On 12/09/25 at approximately 4:30 PM, another surveyor was pulling a roller bag across the same sidewalk when the bag caught in a large hole, causing the surveyor to stumble and the bag to be propelled from their hand.On 12/12/25 at approximately 9:00 AM, Resident #5's family member requested to speak with a surveyor and reported ongoing concerns regarding the condition of the facility sidewalks. The family member stated these concerns had been reported to facility staff for several months. The family member described an incident that occurred in late spring when a wheel of Resident #5's wheelchair became lodged in a hole in the sidewalk, nearly causing the resident to be lunged forward from the chair. The family member further reported that water pools in front of the facility's entry door during rain events. The family member stated that approximately one month prior, they directly informed the Nursing Home Administrator (NHA) of these concerns and were told the facility would contact appropriate parties; however, no corrective action or follow-up had occurred.On 12/12/25 at approximately 9:15 AM, a surveyor observed three concrete sidewalks and a concrete patio area. The surveyor noted multiple uneven areas where the concrete had buckled, as well as sections where concrete had broken away, leaving holes. The patio contained several very large holes, gapping several inches. The surveyor further noted that the lawn grading slopes toward the building entrance, contributing to water accumulation at the entry door.On 12/12/25 at approximately 9:34 AM, the surveyor reviewed the facility's survey binder and identified that the facility had previously been cited on 05/22/23 for unsafe sidewalk and patio conditions. The prior Plan of Correction (POC) stated, in part:1. Cracks in the sidewalk would be repaired by maintenance by 08/31/23.2. All residents using the sidewalk had the potential to be impacted.3. The NHA and Maintenance Director would conduct weekly walking rounds of sidewalks and patios, with corrective action taken at the point of discovery.4. The Quality Assurance Committee would evaluate the issue for three months or until substantial compliance was achieved.On 12/12/25 at approximately 9:52 AM, the surveyor interviewed the Facility Maintenance Director (FMD #25), who stated he conducts environmental rounds at least once every couple of weeks. When asked if these rounds included sidewalks, he stated he was aware the sidewalks and patio needed repairs and reported that he requested approval to complete repairs in the spring, but the repairs were not approved. He stated the NHA was aware of the issue and that corporate offices had refused to authorize repairs. He further stated that the slope of the sidewalk causes water to collect and that family members had complained about the sidewalk conditions. On 12/12/25 at approximately 10:06 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA) and asked what the facility process is when it is discovered that repairs are needed. The NHA stated that he is responsible for obtaining three vendor quotes, which are then forwarded to the Regional [NAME] President and the corporate office. He stated that corporate determines the significance or priority of the repair or may decide to put it on the backburner.When asked if he was aware of any current repair concerns, the NHA stated that he was aware the sidewalks and patio need repair. He stated, We are having trouble getting vendors to give us an estimate for our sidewalks because they think the job is too small. The NHA then stated that it is actually a big job due to the slope and that every time it rains, water pools at the front door. He stated that the Maintenance Director (FMD #25) had reached out to vendors to obtain quotes.When asked if corporate leadership was aware of the sidewalk and patio issues, the (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NHA stated, Yes, I think that it was brought up over the summer. The surveyor asked if he had informed corporate leadership that the facility was having trouble obtaining vendor estimates. The NHA stated that corporate instructed him to broaden the vendor search. When asked if he had done so, the NHA stated that he hasn't pounded the pavement. When asked to clarify, the NHA stated that he had made some attempts but acknowledged he had not kept a list of vendors contacted, had not retained any quotes, and stated, Effectively, I have not been keeping track.When asked if any residents or family members had complained about the sidewalks or patio, the NHA stated that Resident #5's family member had complained.When asked if he was aware that the facility had been cited in 2023 for unsafe sidewalk and patio conditions, the NHA replied, I believe I did hear that. When asked if he was familiar with the prior Plan of Correction, the NHA stated, I read it a while back, but not recently. The surveyor asked whether he had conducted the weekly sidewalk and patio rounds required by the POC, which stated that the NHA and Maintenance Director would complete weekly rounds with corrective action taken at the point of discovery. The NHA stated, No.When asked why the required rounds were not being conducted, the NHA stated, no particular reason, adding that staff walk the building all the time and that they might have noticed if conditions changed. The surveyor asked if the sidewalk and patio conditions were being discussed during Quality Assurance meetings. The NHA stated, We occasionally talk about it, but acknowledged there was no specific plan or tracking in place. The NHA stated that although he was not employed at the facility in 2023, he agreed that addressing environmental safety issues is his responsibility.On 12/12/25 at approximately 10:28 AM, the surveyor interviewed Staff #24, who stated that Resident #5's family member complained after the resident's wheelchair became stuck in the sidewalk, which she believed occurred the previous summer. She stated she notified both the Maintenance Director and the NHA.On 12/12/25 at approximately 10:33 AM, the surveyor interviewed Staff #20, who stated that several residents and family members had complained about the sidewalk conditions. Staff #20 stated, When it rains, a puddle develops in front of the entry door, and reported that multiple complaints had been made by family members, a social worker, the Ombudsman, GTS, and paramedics.On 12/12/25 at approximately 11:20 AM, the surveyor interviewed the Director of Nursing (DON), who stated she was aware that the sidewalk had been an issue for many years. She stated that prior repairs consisted of patching, which had not been effective. The DON reported that plans to fix the sidewalk existed prior to the current Maintenance Director but were not carried forward. She confirmed awareness of the 2023 citation and stated the sidewalk had been an issue since 2019. She further stated that previous repair quotes were obtained but were considered too expensive, and therefore repairs were not completed.Cross Reference F585

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, interview, and observation it was determined that the facility failed to develop a comprehensive person-centered care plan and failed to ensure that care plan interventions were implemented. This was found to be evident for two (Resident's # 3 and #2) out of two residents reviewed for accidents and for one (Resident #49) of two residents reviewed for Respiratory Care. The findings include: 1) Review of Resident #3's medical record revealed the resident was admitted to the facility in June 2025. On 12/8/25 at 9:14 AM the resident was observed in bed, no fall mats were observed on either side of the resident's bed. On 12/10/25 review of the resident's care plans revealed a plan to address risk for falls related to weakness and dementia. This plan was originally initiated in July 2025 and in October 2025 the interventions were updated to include: Fall mat to right side of bed. A care plan evaluation note, written on 12/9/25, revealed the resident had two falls during the current look back period, one on 10/16/25 and one on 11/21/25. Review of the progress note, dated 11/21/25 revealed the resident was found on the floor beside his/her bed. The note does not indicate if the fall mat was in place when the resident was found on the floor on 11/21/25. Further review of the medical record failed to reveal documentation to indicate the intervention of fall mats was implemented. On 12/11/25 at 10:49 AM the resident was observed in bed, no fall mat was observed on either side of the bed. At 10:52 AM Nurse #17 was asked if Resident #3 had fall mats. The Nurse responded with: let me see what the care plan says. The nurse proceeded to find the fall mat intervention in the care plan. Nurse #17 and surveyor then observed the resident in bed, and the nurse confirmed there was no fall mat in the room at this time for Resident #3. On 12/12/25 at 9:00 AM surveyor reviewed with the Director of Nursing the concern regarding failure to ensure care plan interventions for fall mats were implemented for Resident #3. 2) Review of a facility reported incident (2594490) revealed that on 9/1/25 Resident #2 was attempting to pick up a book off the floor and fell out of the wheelchair. The resident sustained a hip fracture that required surgical repair. The corrective action included on the facility's final report was: Intervention of anti-roll back device to wheel chair. On 12/10/25 review of the medical record revealed a care plan for falls, that was in place since 2024, was updated on 9/1/25 to include anti-roll back to wheel chair. On 12/11/25 at 1:36 PM the resident was observed sitting in a wheelchair near the nursing station. No anti-roll back device was observed on the wheelchair at this time. On 12/11/25 at 1:35 PM the therapy director (#29) reported she was familiar with the resident and confirmed that the resident is not able to ambulate but indicated the resident sometimes tries to stand up. Surveyor and therapy director then observed the resident seated in the hallway and the therapy director #29 confirmed an anti-roll back device was not on the wheelchair the resident was currently seated in. Therapy Director #29 then went to look for the device, and at 1:38 PM reported she was unable to find an anti-roll back device for this resident and indicated she would contact maintenance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/25 at 9:00 AM surveyor reviewed with the Director of Nursing the concern regarding failure to ensure care plan interventions for anti-roll back device were implemented for Resident #2. 3) A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff use care plans to deliver resident-centered care, including support, services, and resources to meet Residents' needs. During an observation on 12/8/2025 at 8:50 AM, Resident #49 was observed in bed receiving oxygen via nasal cannula at 1 L/min. A review later that day of Resident #49's current provider's orders included an order initiated on 3/3/25 for oxygen at 2 L/min via nasal cannula for chronic obstructive pulmonary disease (COPD), a progressive lung disease that makes breathing difficult. Continued review of Resident #49's care plan failed to show that the Resident's oxygen use was addressed in his/her care plan. During an interview on 12/9/2025 at 12:27 PM, staff #30, an MDS nurse, said she was responsible for updating residents' care plans. She reviewed Resident #49's current care plan and confirmed it lacked information about Resident #49's oxygen use. In a subsequent interview with staff #30 on 12/9/2025 at 3:00 PM, she reported that Resident #49's care plan had been updated to reflect the Resident's use of oxygen following the surveyor's intervention.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview it was determined that the facility failed to provide Geriatric Nursing Assistants (GNAs) required training. This was evident for 3 of 5 GNAs (GNA #8, GNA #9, GNA #10) reviewed for evidence of required training during the Staffing task portion of the annual survey.The findings include:On 12/09/25 training records were requested for 5 randomly selected GNAs.On 12/10/25 a review of the training records revealed failed to reveal that:GNA #8 had any abuse, dementia, or infection control trainingGNA #9 had any abuse or infection control trainingGNA #10 had any infection control trainingOn 12/12/25 at 12:15 PM the Director of Nursing (DON) was asked if she had any additional evidence of training for GNA #8, GNA #9, or GNA #10. She said that Human Resources may have documentation.On 12/12/25 at 12:25 PM an interview was conducted with the Human Resources Director (Staff #11) to ask for evidence of training for GNAs #8, #9, and #10, and she said she would look.On 12/12/25 at 12:58 PM another interview was conducted with Staff #11 regarding training records. She said she had reached out to the agency the GNAs worked for to see if they could provide training records. No sufficient evidence was submitted prior to the survey exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, it was determined that the facility failed to ensure that a resident who required assistance with self-care was groomed in a manner that preserved the Resident's dignity. This was evident for 1 (Resident #12) of 1 resident reviewed for dignity.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions.An observation on 12/8/2025 at 2:14 PM revealed Resident #12 seated in a wheelchair in the locked unit hallway. The Resident was noted to have facial hair on the chin and upper lip.A subsequent observation on 12/9/2025 at 8:08 AM showed that Resident #12 continued to have facial hair.Later that day at 4:14 PM, Resident #12 was observed seated in a wheelchair at the nurses' station, still with facial hair.Record review on 12/11/2025 at 9:28 AM included an admission MDS assessment for Resident #12. The MDS noted that Resident #12 had severely impaired cognition and required maximal assistance from staff with personal hygiene.The continued review of Resident #12's care plan failed to reflect the Resident's preference to wear facial hair.In an interview on 12/11/2025 at 9:30 AM, Resident #12 stated that s/he would like his/her facial hair shaved.During an interview on 12/11/2025 at 9:38 AM, staff #28, a geriatric nurse aid, reported that Resident #12 was able to propel himself/herself in the wheelchair and feed himself/herself but required staff assistance with all other self-care needs, including shaving. The staff was questioned about the facial hair on Resident #12's face and responded, I will shave him/her immediately. Later that day, staff #28 reported to the surveyor that Resident #12's facial hair had been shaved following the surveyor's intervention. Staff #28 added that it should have been done long ago.In an interview on 12/11/2025 at 10:54 AM, the director of nursing stated that she expected Resident #12's facial hair to have been shaved if the Resident preferred it shaved.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on medical record review and interview it was determined that the facility failed to ensure the risks and benefits of a psychoactive medication was discussed with the resident and or the responsible representative prior to the start of treatment with psychoactive medication. This was found to be evident for one (Resident #20) out of five resident's reviewed for unnecessary medications.The findings include:Review of Resident #20's medical record revealed the resident was admitted in February 2024 with diagnosis including, but not limited to, history of stroke, heart disease, and non-Alzheimer's dementia. At the time of admission the resident did have orders for the antidepressant Prozac, but did not have orders for antipsychotic medication. Review of a 2/23/24 progress note revealed the resident had an identified surrogate decision maker (responsible representative). On 3/5/24 the resident was deemed incapable of understanding information contained on documents and forms due to dementia prior to stroke. Review of the medical record revealed a Consent for Psychoactive Medication form, completed by the Director of Nursing, on 3/27/25, for the use of Remeron, an antidepressant. This form includes information regarding the specific conditions to be treated, the beneficial effects and the clinically significant side effects or risks associated with the medication; and the proposed course of the medication. The form indicated Verbal Consent was given to use psychoactive medications. This form indicates it was reviewed with the resident and failed to include documentation to indicate the resident's responsible representative was informed or consulted regarding the use of the Remeron. Review of a 5/2/24 psychiatric provider note revealed the provider was asked to see the resident for delusions and hallucinations. The note indicated the resident was currently receiving Remeron and Prozac, and a plan to start Seroquel (an antipsychotic medication) 25 mg two times a day for delusion and hallucination. Further review of the Consent for Psychoactive Medication form revealed the following side effects or risks associated with Antipsychotic medications: neck stiffness, confusion, muscle rigidity, involuntary movements, drooling, tremors, restlessness, sleep disturbances, dry mouth, blurred vision, constipation and sedation). Review of a 5/4/25 progress note confirmed the Seroquel was started. Further review of the medical record failed to reveal documentation to indicate the resident or the resident's representative was informed of the risks involved with the use of this antipsychotic medication prior to it being started. On 12/10/25 review of the medical record revealed the resident had a current active order for Seroquel, an antipsychotic medication, to be administered two times a day. No documentation was found to indicate a Consent for Psychoactive Medication form was completed related to the use of the Seroquel. On 12/12/25 at 9:00 AM surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to ensure informed consent prior to the start of psychiatric medication. DON confirmed there is a form that they use for the consent. Surveyor requested documentation of informed consent for the Seroquel, if there was any. As of time of survey exit on 12/12/25 at 1:30 PM no additional documentation was provided regarding this concern.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure residents, and or responsible representatives, were asked about advance directives and that responsible decision makers were involved in the determination of orders regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options. This was found to be evident for one (Resident #3) out of three residents reviewed for Advance Directives.The findings include:On [DATE] review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnosis that included, but not limited to, dementia, heart disease and lung disease. The Primary Care Physician (PCP) #18 completed the Admitting History and Physical on [DATE]. This note indicates the resident had an Advanced Directive that was reviewed, however, further review of the medical record failed to reveal the presence of an advance directive or documentation of a health care power of attorney.Review of the Social Worker notes failed to reveal documentation to indicate Advanced Directives were discussed with the resident or a responsible representative.Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form that includes orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. The first section of the MOLST includes an area for the provider to certify who these orders were discussed with and who provided informed consent. Although, according to the physician progress notes, the resident was first seen by the PCP #18 on [DATE], PCP #18 signed the first page of the resident's MOLST form on [DATE]. Review of this MOLST form revealed orders for No CPR, as well as orders to not use artificial ventilation, artificially administered fluids or nutrition, no dialysis and to limit hospital transfer and medical tests. Further review of the medical record failed to reveal documentation in regard to whom these orders were discussed with or who provided informed consent for them. The second page of the MOLST was dated [DATE] and the name of the PCP was handwritten in a different handwriting than on the first page. During an interview with the Director of Nursing on [DATE] she reported she did not recognize the handwriting on the second page.Review of the Evaluation of Resident's Ability to Make Informed Healthcare Decisions form revealed that the the attending Primary Care Provider determined on [DATE], that the resident was unable to understand the nature, extent, or probably consequences of the proposed treatment or course of treatment; and was unable to make rational evaluation of the burdens, risks and benefits of the treatment or course of treatment; and recommended that the resident's healthcare decisions be made by a third party decision maker. The area for a second physician to document regarding the resident's ability to make health care decisions was noted to be blank. On [DATE] at 10:26 AM surveyor reviewed the concern with the Director of Nursing that the MOLST failed to include who the physician spoke with regarding the MOLST, and that the second page was dated [DATE]. Surveyor also reviewed the concern that the physician progress note indicated there was an Advance Directive, but review of the medical record failed to reveal documentation of an Advance Directive and that certification of incapacity to make decisions was only signed by one provider.Interview on [DATE] at 10:37 AM with Social Worker #23 revealed that for new admissions she checks for Advance Directives and discusses them with residents and responsible representatives. SW #23 confirmed that she would include this information in a progress note. In regard to Resident #3, SW #23 reported this resident was admitted before she started covering, which was at the end of August.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure the primary care physician and the registered dietitian were made aware of the identification of continued significant weight loss in a timely manner. This was found to be evident for one (Resident #3) out of three residents reviewed for nutrition.The findings include: On 12/10/25 review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnosis that included, but not limited to, dementia, heart disease and lung disease. Further review of the medical record revealed the resident's weight on 6/24/25 was 144 lbs. On 7/28/25, 8/1/25 and 8/3/25 the resident's weight was recorded as 135.7 lbs. This 8.3 lbs weight loss represents a significant weight loss of 5% in one month. The 8/3/25 Primary Care Provider (PCP #18) note failed to acknowledge or address this significant weight loss. Review of the Registered Dietitian (RD #27) note, dated 8/29/25 states Current weight is 135.7. This 135.7 lbs is the weight from 3 weeks prior to the 8/29/25 assessment The note addresses the significant weight loss of 5.6 % in 1.5 months, but also documented that the resident was recently treated with antibiotics for a urinary tract infection and that intakes are much better since treatment was completed. The stated plan was to monitor intakes and weights.On 9/1/25 the resident had a recorded weight of 126.2 lbs, indicating an additional loss of 9.5 lbs since 8/1/25. This represents a significant weight loss of 12% of the resident's body weight in two months. No documentation was found to indicate that either the RD or the PCP were notified of the significant continued weight loss identified on 9/1/25.On 12/11/25 at 10:13 AM the surveyor reviewed the concern with the Director of Nursing that a significant weight loss was present on 9/1/25 but no documentation was found to indicate the RD or MD was made aware.Further review of the medical record revealed the resident was seen by the PCP on 9/30/25. This note included a notation of weight loss monitorying, but failed to address the significance of the current weight loss or a plan to address it.The resident's weight on 10/2 and 10/4 were both 124.6 lbs.The resident's weight on 11/2 and 11/6 were both 118.2 lbs, representing an additional 5% loss in one month.Further review of the medical record failed to reveal documentation that the RD was aware of the continued significant weight loss, until 11/8/25. Review of the RD note, dated 11/8/25, revealed the resident was not on a supplement so the RD would speak to the resident about possible use of supplement at a later date. On 11/22/25 RD #27 documented the weight loss of 18.1 % in 5 months and the recommendation to start a supplement (magic cup - an ice cream like item) twice a day to help provide extra nutrition due to weight loss. A corresponding order for the magic cup twice a day was found for 11/22/25.Further review of the medical record revealed the resident was seen by PCP #18 on 11/30/25. This note stated: In the last 4 weeks: no wounds, no falls, no infections or antibiotics, weights reviewed, no ER visits or hospitalizations. This note failed to acknowledge or address the significant weight loss of 18% of the resident's body weight since admission. On 12/12/25 at 11:29 AM RD #27 was interviewed via phone call, with the Director of Nursing present. RD #27 reported that she has worked at the facility since June of 2025 and comes to the facility 2-3 days per week. When asked how she is notified of significant weight changes, RD #27 reported she can run a report so she can see those changes, indicating the report is for everyone that they obtain weights on. RD acknowledged Resident #3 was having weight loss and stated: I just do not know why. When asked about the failure to address the significant weight loss that was identified on 9/1 until November, RD #27 reported: from June thru September there were two dietitians, it wasn't until October that she took over full time and indicated another RD may have addressed the loss. At this time the DON confirmed that there were no additional RD notes. Surveyor reviewed the concern that the facility staff failed to ensure the RD and or the PCP were made aware of the continued weight loss.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews, observations, and record review, it was determined that the facility failed to enter, investigate, and follow up on grievance in a timely manner. This failure was identified while performing the Resident Council task and was evident for 1 of 1 grievance reviewed in the facility's grievance log.The findings include:A grievance in a long-term care facility is a formal complaint or expression of dissatisfaction by a resident or the resident's representative regarding any aspect of care, resident rights, or the facility environment. Federal and state regulations require the facility to record all grievances, conduct a timely investigation, and provide a written decision to the complainant outlining the findings (if requested) and any corrective actions taken within required timeframes.On 12/09/25 at 3:24 PM, the surveyor interviewed Resident #37, identified as the [NAME] President of the Resident Council. When asked who oversaw grievances, the resident identified the Nursing Home Administrator (NHA). When asked how to file a grievance, the resident stated that they could tell a nurse, who would then provide a paper form to complete.Immediately following this interview, the surveyor observed a grievance notice posted on a bulletin board. The notice stated:Oakland Nursing and Rehabilitation Center Notice of Grievance Official In accordance with F585: Notifying resident individually or through posting in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file a grievance anonymously; the contact information of the grievance official with whom the grievance can be filed.The notice included the NHA's contact information and a confidential voicemail number. It further stated, This facility utilizes three business days to investigate and resolve grievances. If the above is not available any staff member is able to assist in the filling out or filing of a grievance: please contact Social Services or the Administrator for more information.On 12/12/25 at 9:00 AM, Resident #5's family member requested to speak with a surveyor and reported ongoing concerns regarding the condition of the facility sidewalks. The family member stated that the issues had been reported to facility staff for several months. The family member described an incident that occurred in late spring in which Resident #5's wheelchair wheel became lodged in a hole in the sidewalk, nearly causing the resident to be lunged from the chair. The family member further reported that when it rains, water accumulates in front of the entry door. The family member stated that approximately one month prior, they had directly informed the NHA of these concerns and were told the facility would contact the appropriate parties; however, no corrective action or follow-up had occurred. The family member stated that the next step would be contacting the corporate office because the NHA had largely ignored their concerns.On 12/12/25 at 10:06 AM, the surveyor interviewed the NHA regarding facility repair concerns. He stated that he was aware that the sidewalks and patio required repairs and that water pools at the front door during rain. When asked if corporate was aware, he replied, Yes, I think that it was brought up over the summer. The NHA confirmed that he served as the grievance officer and acknowledged that Resident #5's family had voiced concerns about the sidewalk to the receptionist. When asked if he had followed up with the family member, he stated, No, not with them, explaining that although he had three days to respond to grievances, he did not do so because they didn't officially turn in a grievance. The surveyor then requested the facility's grievance policy and procedures.On 12/12/25 at 10:28 AM, the surveyor interviewed Staff #24, who stated that Resident #5's family member had complained after the resident's wheelchair became stuck in the sidewalk, which she believed occurred last summer. She reported that she notified both the Maintenance Director and the NHA. When asked about the grievance process, she stated, Well, I know I am supposed to tell the NHA. She explained that a supervisor is supposed to provide a grievance form but stated that she was never given a form for this complaint.On 12/12/25 at 10:33 AM, the surveyor interviewed Staff #20, who reported that several residents and family members had complained about the sidewalk, stating, Oh, yeah, several people. When asked who had complained, Staff #20 stated, (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Who hasn't heard about the issue? When it rains a puddle develops in front of the entry door. Staff #20 stated that there is a formal grievance process and that grievance forms are completed. They further stated that Multiple people have filed complaints such as family, social worker, Ombudsman, GTS, and the paramedics.On 12/12/25 at 11:11 AM, the surveyor requested and reviewed the facility grievance log with the NHA. The log contained seven grievances from 2025; none addressed the sidewalk concerns. When asked to expand the date range to 2023, the NHA produced one maintenance grievance related to a power cord. The NHA stated that no grievances regarding the sidewalk had been entered. When asked about paper grievance forms, the NHA stated that he keeps them but was unable to produce any. When asked for clarification, he stated, Well, I would keep them if I had any, I could check with the social worker to see if she has any. The NHA confirmed that grievance forms should be immediately submitted to him and that he would respond within three days. When asked if he agreed that the grievance procedure should have been followed for this complaint, the NHA stated, Yes, it should have.On 12/12/25 at approximately 12:00 PM, the surveyor reviewed the facility policy and procedure titled Complaints/Grievance Process, which states, in part, that the facility's leadership will support the resident's right to voice grievances regarding concerns about services and treatment received, including but not limited to environmental issues. The policy further states that facility leadership will accept grievances from residents and resident family members, act promptly to understand and resolve grievances, and, after receiving a grievance, seek problem resolution while keeping the resident informed of the progress toward a solution. The policy also states that the facility honors the resident's right to a written decision regarding a filed grievance when requested.The policy identifies the Grievance Official as responsible for overseeing the grievance process, receiving and tracking grievances through their conclusion, and ensuring that all written grievance decisions include a summary statement of the date the grievance was received; a summary of the grievance; steps taken to investigate; pertinent findings or conclusions; a determination of whether the grievance was confirmed or not confirmed; any corrective action taken; and the date the decision was issued.Cross-reference to F921

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and interview it was determined that the facility failed to ensure written transfer notice and bed hold policy information was provided to the resident and the responsible party when the resident was transferred to the hospital. This was found to be evident for two (Resident #2 and #5) of the three residents reviewed for hospitalizations.The findings include:1). On 12/11/25 review of Resident #2's medical record revealed the resident sustained a fall on 9/1/25 and was sent to the hospital. Further review of the medical record failed to reveal documentation to indicate the required written transfer notice or the bed hold policy was provided to either the resident or the resident's responsible party. On 12/11/25 at 1:41 PM Nurse #17 was interviewed in regard to the process when a resident is sent out to the hospital. Nurse #17 referenced a Continuity of Care Document (CCD); and a paper bed hold document. Nurse #17 did not mention a transfer notice and indicated he was unfamiliar with a transfer notice document. Review of the CCD document revealed it contained the information required to be provided to the receiving institution, however further review of Resident #2's medical record failed to reveal documentation that the CCD was sent to the hospital with the resident. On 12/11/25 at 1:58 PM the Director of Nursing (DON) confirmed that they send the CCD when a resident is transferred to the hospital but did not know if they specifically document that the CCD is sent. Surveyor informed the DON that no documentation was found to indicate the transfer notice or the bed hold was provided to for Resident #2's September discharge to the hospital and that no documentation was found to support that the CCD was sent to the hospital. On 12/11/25 at 2:05 PM during an interview with the Assistant Director of Nursing (ADON #22), while on Unit 4, surveyor was provided with a packet of information that included a Notice of Discharge or Transfer that had areas to document the resident's name and why they were being discharged , but failed to include an area to document where the resident was being transferred to. The packet also included the Bed Hold policy information. The ADON reported she fills out the Bed Hold page but confirmed she does not fill out the transfer information. Further review of the packet provided from Unit 4 revealed it was signed by a previous nursing home administrator on 1/15/19. In a follow up interview on 12/11/25 at 2:10 PM on Unit 2, Nurse #17 provided a packet of information, stating that he fills out the first page and gives that page to the Director of Nursing and the rest of the packet to the resident. Review of the packet Nurse #17 provided revealed that the page that he indicated he gives to the DON was actually the first page of the Notice of Discharge or Transfer that included the required information about where the resident was being discharged to, why they were being discharged and that they have the right to appeal. On 2/11/25 at 2:34 PM surveyor reviewed with ADON #22 the concern that the version of the transfer notice being provided from Unit 4 was incorrect and the other version was correct but staff were not providing it as required. ADON acknowledged that Unit 4 needed updated forms and that staff need to be educated about the use of the transfer notice. On 2/12/25 at 9:00 AM surveyor reviewed with the DON the concern regarding the failure to ensure appropriate transfer notice and bed hold policy were provided to residents/responsible (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representatives and failure to have documentation that the CCD information was sent to the hospital at the time of transfer. As of time of survey exit on 12/12/25 at 1:30 PM no documentation was provided to indicate the transfer notice or the bed hold policy was provided to Resident #2 or their responsible representative. 2). On 12/08/25 at 10:27 AM, during the screening process of the survey, the surveyor interviewed Resident #5, who stated they were recently hospitalized . Subsequent review of Resident #5's medical record revealed a progress note dated 11/27/25 which stated, in part:Resident #5 was complaining of nausea, vomiting, intermittent constipation and abdominal pain. Doctor gave orders to send resident to ER for eval and treatment. Called emergency contact to let [them] know s/he was going to the hospital. On 12/11/25 at 9:35 AM, the surveyor reviewed Resident #5's medical record and was unable to find evidence that the resident or their representative was provided with written notification of transfer or a bed-hold notice. On 12/11/25 at 2:27 PM, the surveyor requested evidence of transfer notification and bed-hold documentation. At 3:27 PM, the Assistant Director of Nursing (ADON) provided a document titled Request for a Temporary Leave Bed-Hold for Resident #5. The ADON stated the form had been signed by the resident but acknowledged it had not been completed. She further stated the facility was unable to locate any evidence of a written transfer notice. Surveyor review of the Request for a Temporary Leave Bed-Hold document stated, in part,I further (select one) ___ Request ___ Do not request, that a bed be held during my/resident's leave from the facility beginning ____. Resident will return to the facility on _____ (insert anticipated date of return), was left blank. The form also lacked the date, room number, anticipated return date, and witness signature. At 3:30 PM, the surveyor informed the Director of Nursing (DON) that the facility was unable to provide evidence of a transfer notice and that the bed-hold form had been presented to the resident for signature without being completed. The DON stated she would look in her pile for the transfer notice. On 12/11/25 at 4:21 PM, the DON confirmed during interview that the transfer notice could not be located and acknowledged that both the incomplete bed-hold documentation and missing transfer notice were concerns.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 1 (Resident #6) out of 1 resident reviewed for position and mobility. The findings include:The MDS (Minimum Data Set) is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need.An observation of Resident #6 on 12/8/2025 at 9:30 AM revealed contractures in the left hand (fingers bent at the knuckle joints and unable to straighten). Resident #6 was unable to lift both hands. A record review for Resident #6 on 12/10/2025 at 4:20 PM included a hospital admission history and physical dated 4/29/25, which noted that the Resident had a stroke in 2022, resulting in left-sided paralysis (weakness).The continued review included an admission observation for Resident #6 dated 5/15/25. The assessment noted contractures in the Resident's left upper and lower extremities and right lower extremity.Further review of an occupational therapy (OT) evaluation dated 5/16/25 for Resident #6 documented an impaired range of motion (ROM) in the Resident's left shoulder, elbow, forearm, and wrist. However, a review of Resident #6's admission MDS dated [DATE] showed that Resident #6 had no functional limitations in the range of motion of any of his/her upper and lower extremities.A subsequent review of another OT evaluation dated 10/7/25 and a PT evaluation dated 11/6/25 indicated that Resident #6 had impaired ROM in both upper and lower extremities.However, Resident #6's MDS assessment dated [DATE] documented one-sided ROM in the left and right extremities.In an interview on 12/11/2025 at 4:49 PM, staff #30, an MDS nurse, stated that part of documenting impaired ROM in the MDS involved reviewing therapy evaluations and notes. Staff confirmed that Resident #6's ROM impairment was inaccurately reported on his/her MDS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews it was determined that the facility failed to ensure baseline care plan information was provided to the resident and or the responsible representative. This was found to be evident for 3 (Resident #3, #20 and #55) out of the 15 residents included in the survey sample.The findings include:Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.1) Review of Resident #20's medical record revealed the resident was admitted in February 2024. Further review of the medical record failed to reveal documentation to indicate the resident, or a responsible representative was provided a copy of the baseline care plan information.2) On 12/10/25 review of Resident #3's medical record revealed the resident was admitted to the facility in late June 2025 but no documentation was found to indicate the resident's baseline care plan was provided to either the resident or a responsible representative.On 12/11/25 at 10:13 AM the Director of Nursing (DON) reported that the Baseline care plan is completed and presented to the resident usually between 24-48 hours after admission. The DON indicated either she or social services presents the baseline care plan information and confirmed this should be documented in the medical record. Surveyor then reviewed the concern that no documentation was found to indicate the baseline care plan was provided to Resident #3 or #20. This concern was again reviewed with the DON on 12/12/25 at 9:00 AM. 3) Review of Resident #55 medical record revealed the resident was admitted on [DATE]. On 12/12/25 further review of the medical record failed to reveal documentation to indicate the baseline care plan was provided to either the resident or resident representative.On 12/12/25 at 9:39 AM the DON reported that the social worker (SW) may have given the baseline care plan to the resident, but confirmed there was no documentation to indicate the baseline care plan was provided. At approximately 9:45 AM a phone interview was conducted with SW #23, in the presence of the DON. SW #23 confirmed that she did not review the baseline care plan with the resident.As of time of survey exit on 12/12/25 at 1:30 PM no additional documentation was provided to indicate the baseline care plan was provided to Resident #20, #3, or #55.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure that residents who were dependent on staff for Activities of Daily Living (ADL) received oral care. This was evident for 1 (Resident #6) of 2 residents reviewed for ADL. The findings include: In an observation on 12/8/2025 at 9:34 AM, Resident #6 was observed lying in bed. The Resident's lips were dry and crusted.Later that day at 12:18 PM, staff #19, a licensed practical nurse, was present in Resident #6's room, confirmed that the Resident's lip was dry and crusted, and stated it needed to be cleaned with a swab.In a subsequent observation on 12/9/2025 at 8:55 AM, Resident #6's crusted areas on his/her lips remained.A record review later that day contained an MDS assessment (Minimum Data Set- a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs) dated 11/21/25 for Resident #6. The MDS documented that Resident #6 relied on staff for all self-care needs.Further review included an ADL care plan for Resident #6, which recorded that the Resident required staff assistance with oral hygiene. The care plan goal stated that staff will assist the Resident with oral hygiene as needed. (A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care).However, earlier observations showed that the Resident's lips were dry and crusted.In an interview on 12/9/2025 at 1:56 PM, staff #19 reported that she attempted to remove the crust on Resident #6's lips after the surveyor's intervention. However, the crusted areas were not easy to remove at the time. Staff said she could only remove the crust later after applying petroleum.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review, it was determined that the facility failed to provide an ongoing program of activities that met residents' needs and preferences. This was evident for 1 (Resident #6) out of 3 residents reviewed for activities.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care.An interview with Resident #6's representative on 12/8/2025 at 11:49 AM showed that the resident was bed-bound and was not engaged in Activities.During multiple observations during the recertification survey, Resident #6 was observed lying in bed, yelling, and not involved in any activity.A review of Resident #6's medical record showed that the resident's diagnosis included, but was not limited to, Dementia and had severely impaired cognition.Continued review of Resident #6's admission MDS assessment dated [DATE] showed that it was very important to him/her to do his/her favorite activities, such as keeping up with the news, going outside for fresh air when the weather was good, listening to music s/he liked, be around animals such as pets, and participating in religious services or practices. Further review of Resident #6's care plan included an activity focus initiated on 5/21/2025 and updated on 11/25/25 that stated, [Resident #6] is dependent upon staff to meet his emotional, intellectual, physical, and social needs. The interventions on the care plan included the following: Staff will provide music of interest during one-to-one visits, Staff will provide one-to-one visits that are religious/spiritual, Staff will read to [Resident #6] during one-to-one visits, Resident will be outdoors, and Staff will provide music of interest during one-to-one visits. However, a review of Resident #6's activity logs for October 1 to December 8, 2025, revealed that the only activity provided to the resident during this period was Chronicle/puzzle. The activity log included a participation column that recorded U for Resident #6.In an interview on 12/11/2025 at 9:38 AM, Staff #6, an activity aid, indicated that Chronicle/puzzle recorded in Resident #6's activity log meant that Staff handed newspapers and puzzles to residents. However, Resident #6 was unable/didn't understand what's going on. Staff #6 was asked if she handed newspapers and puzzles to cognitively impaired residents. Staff answered, No, because [s/he] did not understand what's going on.In an interview on 12/11/2025 at 2:22 PM, staff #7, the Activity Director, expressed understanding of the concern regarding the lack of activities for Resident #6, based on his/her activity preferences identified in his/her admission assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interviews, it was determined that the facility failed to ensure appropriate follow-up care after a hospital discharge; and failed to ensure there were orders or care plan interventions for the use and monitoring of an air mattress. This failure was evident for one (Resident #1) of two residents reviewed for catheter use; and one (Resident #53) out of one resident reviewed for skin issues.The findings include:1). On 12/08/25 at 11:39 AM, during the initial screening of residents, the surveyor observed that Resident #1 had a large amount of sediment visible within their catheter tubing. On 12/10/25 at 9:46 AM, the surveyor conducted a review of Resident #1's medical record and identified an active care plan related to indwelling catheter use with a problem start date of 06/25/25. The care plan identified that Resident #1 had a Foley catheter due to bladder neck obstruction. Long-term goal included that the resident would not develop a urinary tract infection for 90 days. A note entered into the care plan on 10/14/25 by Staff Nurse #30 stated:[Resident #1] has Foley catheter. [S/he] states it is soon 'coming out.' [S/he] has diagnosis of bladder neck obstruction and nursing is unaware of any plans for removal or change to suprapubic catheter. Foley is cared for by nursing staff. Will continue POC [Plan of Care] until further instructions given. Continue POC. Further review of the resident record revealed the following progress notes: 9/10/25: Resident [#1] is having only dark red blood in catheter currently. MD [physician] notified. 9/10/25: Resident [#1] found to have a catheter full of blood. HGB [lab work] dropped to 7.9 from 12.8. Doctor #18 ordered to have resident transported to the [Emergency Department] for evaluation and treatment. 9/10/25: Resident was admitted to [Hospital name] for acute kidney injury [AKI]. 9/11/25: Resident returned from [Hospital] at [8:00 PM]. Received report from [Hospital LPN] who stated resident had just received Zosyn and Daptomycin [antibiotics] before leaving hospital. Notified Doctor #18 of return and waiting on approval of orders. A progress note dated 9/13/25 documented that Resident [#1] stated that [s/he] wanted to talk to someone about having surgery for placement of a suprapubic catheter [SP catheter]. [Signed by Nurse #15]. The surveyor reviewed the hospital discharge summary, which stated: Resident [#1] was admitted for septic shock related to catheter-associated pseudomonas UTI [Urinary Tract Infection] and enterococcus. Severe AKI [Acute Kidney Injury]. Follow up with urology in two weeks and discuss SPT [suprapubic catheter tube] vs outlet procedure [a surgery that can help free bladder blockages]. A Pseudomonas UTI is a urinary tract infection caused by bacteria. This type of infection is generally considered a complicated UTI and is typically seen in hospitalized patients or those with underlying health issues. An Enterococcus UTI is a urinary tract infection caused by bacteria. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AKI is a condition where the kidneys rapidly lose their ability to filter waste from the blood, leading to a buildup of toxins, fluid imbalance, and problems. Septic shock is a life-threatening stage of sepsis (the body's extreme response to an infection) where a severe infection triggers a massive body-wide inflammatory response and organ dysfunction requiring immediate medical care. On 12/11/25 at 12:54 PM, the surveyor interviewed Resident [#1] about their catheter, and [s/he] stated that the doctor at the hospital suggested that [s/he] see a specialist to be evaluated for a suprapubic catheter and added that [s/he] did not know why [s/he] had not heard any follow-up. S/he said they saw another doctor and thought that they were supposed to have something else done. On 12/11/25 at 12:56 PM, the surveyor interviewed Nurse #30, who confirmed she added catheter-related interventions to Resident [#1]'s care plan, including the care plan note dated 10/14/25. When asked if she was aware of the hospital discharge instruction for the resident to follow up with urology regarding a suprapubic catheter, Nurse #30 stated she could not specifically recall that instruction and stated that she would typically report such recommendations to the Director of Nursing (DON) or the social worker. On 12/11/25 at 1:29 PM, the surveyor interviewed the DON and asked about the process for ensuring that hospital discharge orders are addressed. She stated that the nurse working during the shift in which Resident [#1] returned from the hospital should have reviewed the instructions and notified the DON of the recommendation, to ensure the follow-up appointment was made. She stated, I personally review all discharge summaries that come from the hospital, and that requests typically go to the scheduler so the appointment can be made. She could not recall this particular instance. On 12/11/25 at 1:59 PM, the DON stated she and the Assistant DON reviewed the hospital discharge summary and were trying to determine how the appointment was missed because it appeared to have been on the calendar. On 12/11/25 at 3:35 PM, the DON provided the surveyor with documentation that Resident [#1] was seen by a urologist on 9/25/25 and was recommended to have a cystoscopy (a medical procedure to visually examine the bladder). The DON was unable to answer whether Resident [#1] had been scheduled for the cystoscopy and stated she was checking with admissions staff (#21), who were handling scheduling until a new scheduler was hired. On 12/11/25 at 3:59 PM, Staff #21 notified the surveyor that upon review of the resident appointment calendar, Resident [#1] had been scheduled for a urology/cystoscopy appointment on 10/1/25, but the appointment had been cancelled by the facility. Staff #21 stated that she was unsure why the appointment was cancelled and confirmed that there was no documentation indicating the appointment was rescheduled. On 12/11/25 at 4:14 PM, the surveyor spoke with the DON regarding concerns that no one appeared to know what care Resident [#1] received from urology or what the next steps were. The DON acknowledged the concern and stated the scheduler position had been vacant for several months, with other staff assisting in the interim and that it may have fallen through the cracks. On 12/11/25 at 4:34 PM, Staff #21 informed the surveyor that she determined Resident [#1] had gone to one appointment and had been referred for an outpatient surgical procedure; however, the staff had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cancelled that appointment for unknown reasons. She stated that she was actively working on getting it rescheduled. 2). Review of Resident #53's medical record revealed the resident was admitted in 2024. The resident has a care plan for risk for pressure ulcer/injury related to immobility, decreased cognition, kidney failure, heart disease and fragile skin. This care plan was most recently evaluated/reviewed/revised by Nurse #30 on 10/21/25. On 12/8/25 at 12:43 PM surveyor observed the resident in bed. An air mattress was noted to be on the bed and turned on at this time. On 12/11/25 further review of the medical record, including the physician orders and interventions in the risk for pressure ulcer care plan, failed to reveal documentation about the air mattress. No documentation to indicate what setting it was to be maintained at or that staff were checking it on a regular basis to ensure it was working properly. On 12/11/25 at 4:20 PM Nurse #17 reported that Resident #53 has had multiple problems with their feet and is followed at a wound clinic. Observation of the resident, with Nurse #17, at 4:25 PM confirmed the presence of an air mattress, which was set at 4 and alternating. On 12/11/25 at 4:30 PM interview with the Nurse #30 who reported the resident had chronic wounds which have now healed. When asked how staff monitor an air mattress, Nurse #30 reported: it's probably in under the orders, to be signed off by nursing. Nurse #30 confirmed that she did not see a current order for the air mattress. In regard to her updates to the care plan, she reported that if there is no order it is hard for her to pick up on it. On 12/11/25 at 4:50 PM the Director of Nursing (DON) reported that air mattresses are used mainly for pressure injuries. She reported they bring the need for an air mattress to the interdisciplinary team meeting where it is discussed and then they notify the physician for an order. The DON confirmed there should be an order in place for an air mattress. Surveyor then reviewed the concern that Resident #53 has an air mattress but there is no order and no mention of it in the care plan. DON stated: let me see if it got discontinued. She proceeded to check the electronic health record and stated that she did not see one.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined that the facility failed to ensure that a resident with a limited range of motion received treatment and services to prevent further decline in his/her range of motion. This was evident for 1 (Resident #6) out of 1 resident reviewed for position and mobility. The findings include:An observation on 12/8/2025 at 9:30 AM showed that Resident #6's left hand had contractures (fingers bent at the knuckle joints and unable to straighten), and that no device was in place. Staff #19, a licensed practical nurse, was present and reported that Resident #6 did not wear any device on the left hand. Staff #19 attempted to open the Resident's fingers but was unable to. A record review on 12/10/2025 at 4:20 PM indicated that Resident #6 was admitted to the facility with left-hand paralysis due to a stroke in 2022.The continued review included an occupational therapy (OT) evaluation dated 5/16/2025 for Resident #6. The assessment documented an impaired range of motion (ROM) to the left upper extremity in the shoulder, elbow/forearm, wrist, and hand. The review also noted that the current device in the left hand was a hand roll. However, a review of Resident #6's OT Discharge summary dated [DATE] found no documentation of services or treatments implemented to prevent further decline in Resident #6's range of motion after s/he was discharged from therapy.A subsequent review on 12/11/2025 at 9:16 AM noted another OT evaluation dated 7/31/25 for Resident #6. It was recorded in the assessment that the Resident continued to have an impaired ROM in the left upper extremity. The review also stated that Caregiver Goals were ROM and contracture mngt (management). However, the review did not show that, after discharge from OT on 8/28/25, services and treatment were provided to prevent further decline in Resident #6's range of motion.Further review noted another OT evaluation for Resident #6 dated 10/7/25. The assessment recorded that Resident #6 continued to have impaired ROM in the left upper extremity. The review also noted that Resident #6's right upper extremity had impaired ROM. Resident #6 was discharged from OT on 11/10/25 with a discharge recommendation for a Hand roll/washcloth to be placed on L[left] hand for 5 hours every night.A review of Resident #6's treatment administration record for November 2025 showed that an attending provider's order was initiated on 11/10/25 and discontinued on 11/17/25 to Place rolled up washcloth to left hand, up to 5 hours nightly.During an interview with staff #28, a geriatric nurse aide (GNA), she stated that Resident #6 used to receive a rolled towel on his left hand, but was unaware of why it stopped. In an interview on 12/12/2025 at 9:03 AM, staff #29, the therapy manager, stated that Resident #6 was to use a rolled towel for 5 hours each night and was unsure why the provider's order had been discontinued.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record reviews and interviews, it was determined that the facility failed to ensure that residents' colostomy care was provided by appropriately trained, competent, skilled nursing staff. This was evident for 1 (Resident #6) of 1 resident reviewed for colostomy care. The findings include:A colostomy is an opening (stoma) on the abdomen (belly) that connects the colon (large intestine) to the outside of the body. The colostomy allows stool and gas to leave the body when it can't pass through the anus. Stool is collected in a pouch worn on the outside of the body.A record review for Resident #6 on 12/11/2025 at 6:35 AM showed that the Resident was admitted to the facility with the use of a colostomy due to ischemic bowel (lack of oxygen to the bowels) since May 2025.Continued review of Resident #6's care plan included interventions for colostomy care initiated on 6/4/25 that stated that [Resident #6] has a colostomy. Staff to care for it per facility policy. Further review of the facility's policy named ileostomy/colostomy care showed that staff had to assess peristomal skin [around the stoma]. However, a review of Resident #6's record found no evidence that the stoma site or the surrounding skin were routinely assessed by staff. In an interview on 12/11/2025 at 9:37 AM, staff 13, a licensed practical nurse, stated that she provided colostomy care for Resident #6 by checking the site to ensure it was not leaking or containing air. Staff continued to state that she documented her care of the Resident's colostomy in his/her medical record. However, staff #13 reviewed Resident #6's record and reported that there was no documentation demonstrating that she provided the care.In an interview on 12/11/2025 at 9:44 AM, the director of nursing (DON) stated that, typically, the nurses' aides changed and emptied Resident #6's colostomy bag. The DON was asked whether the nurses' aides assessed the peristomal site. The DON responded that licensed nurses typically assessed the peristomal site. However, the interview lacked supporting documentation demonstrating that licensed nurses cared for Resident #6's colostomy.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on record reviews, observations, and interviews, it was determined that the facility failed to provide appropriate treatment and services to residents receiving tube feedings. This was evident for 1 (Resident #6) of 1 resident reviewed for tube feeding.The findings include:A gastrostomy tube (G-tube) is a feeding tube placed into the stomach through an opening in the stomach wall. If one cannot consume sufficient nutrients, formula, liquids, and medications are administered via a G-tube. The formula containers and delivery systems are changed frequently (daily or every few feedings) to prevent bacterial issues.A record review on 12/8/25 indicated that Resident #6 had been at the facility since May 2025 and required tube feeding for nutritional support.The continued review included a provider's orders for tube feeding for Resident #6. The order specified that the resident was to receive Osmolite 1.5 via the G-Tube pump at 65 mL/hr (milliliters) for 24 hours daily. The order further stated, under special instructions, to Date and label tubing with each change.An observation on 2/8/2025 at 9:34 AM indicated that Resident #6's tube feeding was infusing at 65 mL/hr. However, the observation did not show that the formula bottle or tubing was dated or labeled.Continued observation on 12/8/2025 at 12:18 PM showed that Resident #6's G-tube feeding was still running, and the tubing was neither labeled nor dated. Staff #19, a licensed practical nurse, was present and confirmed that the tubing was neither labeled nor dated.A subsequent observation on 12/11/2025 at 9:49 AM found that Resident #6's formula bottle or tubing was neither dated nor labeled. Staff #13, a licensed practical nurse, was present, confirmed that the tubing or bottle was unlabeled and undated, and added, If it's not dated, someone might not know how long it's been running.In an interview with the director of nursing on 12/11/2025 at 12:58 PM, she stated that her nursing staff were expected to date and label the formula bottle and tubing before hanging them for residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, and interviews, it was determined that the facility failed to follow an attending physician's order to administer oxygen to a resident. This was evident for 1 (Resident #49) of 2 residents reviewed for Respiratory Care. The findings include: During an observation on 12/8/2025 at 8:50 AM, Resident #49 was observed lying in bed and receiving oxygen via a nasal cannula connected to an oxygen concentrator set to 1 L (Liter).During a later observation, staff #19, a licensed practical nurse, was present with the surveyor at Resident #49's bedside. Staff #19 confirmed that Resident #49's oxygen was set to 1 L and stated that it should be set to 2 L. Staff #19 then checked the filter on the back of the oxygen concentrator and said, This is probably why it's on 1 L; the filter is dirty and needs to be changed.A record review for Resident #49 included an attending physician's order, initiated on 3/3/25, for O2 (oxygen) at 2 liters per minute via nasal cannula for chronic obstructive pulmonary disease (lung disease). However, an earlier observation showed that Resident #49 was receiving oxygen at 1 L.In an interview on 12/11/25 with the director of nursing, she stated that her staff was expected to administer oxygen to residents in accordance with the attending physician's orders.

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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. 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.

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

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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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure the resident was seen by the primary care provider every 30 days for the first 90 days of admission. This was found to be evident for one (Resident #3) out of three resident reviewed for nutrition.The findings include:On 12/10/25 review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnosis that included, but not limited to, dementia, heart disease and lung disease. The Primary Care Physician (PCP) #18 completed the Admitting History and Physical on 8/3/25, this was more than 5 weeks after the resident's admission to the facility. The note for this initial visit was recorded on 9/20/25. Further review of the medical record revealed the resident's weight on 6/24/25 was 144 lbs. On 7/21/25 and 8/1/25 the resident's weight was recorded as 135.7 lbs. This 8.3 lbs weight loss represents a significant weight loss of 5% in one month. The 8/3/25 PCP note failed to acknowledge or address this significant weight loss. On 9/1/25 the resident had a recorded weight of 126.2 lbs, indicating an additional loss of 9.5 lbs. This represents a significant weight loss of 12% of the resident's body weight in two months. No documentation was found to indicate that either the RD or the PCP were notified of the significant continued weight loss identified on 9/1/25.Further review of the medical record revealed the resident was seen by the PCP on 9/30/25. This was more than 8 weeks after the initial visit on 8/3/25. So in the first 90 days of the resident's admission the resident was seen by the PCP on only 2 occasions. This note included a notation of weight loss monitorying, but failed to address the significance of the current weight loss or a plan to address it.Further review of the medical record revealed the resident sustained a fall on 11/21/25.On 11/22/25 RD #27 documented a weight loss of 18.1 % in 5 months and the recommendation to start a supplement (magic cup - an ice cream like item) twice a day to help provide extra nutrition due to weight loss. A corresponding order for the magic cup twice a day was found for 11/22/25.Maryland state regulations require residents to be seen by a primary care provider every 30 days, unless the physician has determined they are stable and has written an order for visits every 60 days.Further review of the medical record revealed the resident was seen by PCP #18 on 11/30/25, more than 8 weeks after the 9/30/25 visit. This note states: In the last 4 weeks: no wounds, no falls, no infections or antibiotics, weights reviewed, no ER visits or hospitalizations. This note failed to acknowledge or address the significant weight loss of 18% of the resident's body weight since admission. It also erroneously documented that the resident had not had any falls in the past 4 weeks.On 12/12/25 at 9:00 AM surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure the PCP visited the resident every 30 days for the first 90 days.As of time of survey exit on 12/12/25 at 1:30 PM no additional documentation was provided to indicate the resident was seen on additional occasions by the PCP.

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	215232	A. Building B. Wing	12/12/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview it was determined that the facility failed to have separately locked, permanently affixed compartments for the storage of controlled drugs that required refrigeration. This was found to evident in two out of the two medication storage rooms in the facility. The findings include: On 12/9/25 at 2:52 PM observation of Unit 2's medication storage room, with Nurse #19, revealed the medication refrigerator contained a locked box. Nurse #19 reported this box was used for the storage of Ativan when there is a resident who requires this medication. The refrigerator door did not have a locking mechanism, and the box was not permanently affixed in the refrigerator. The key to this narcotic box was observed to be kept inside the unlocked refrigerator, attached to the shelf on the door. Nurse #19 was observed removing the box from the fridge and unlocking it with the key stored in the refrigerator.On 12/9/25 at 3:00 PM observation of the Unit 4 medication room with Nurse #13 revealed a locked narcotic storage box in the unlocked refrigerator. Nurse #13 confirmed that the locked storage box could be removed from the refrigerator. Review of the facility's Pharmacy Services Policies and Procedures Section 8 - Medication Storage 8.2 General Guidelines for Storage of Medication and Biologicals revealed: 9. All scheduled medications and other drugs subject to abuse are stored in a separate, permanently affixed area and are under double lock. On 12/9/25 at 3:20 PM surveyor reviewed the concern with the Director of Nursing and the Clinical Services Director regarding the failure to ensure the narcotic storage box in the medication refrigerator was secured.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview it was determined that the facility failed to ensure the medical record accurately reflected the resident's need for and use of supplemental oxygen. This was found to be evident for one (Resident #3) out of two residents reviewed for respiratory care.The findings include: Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with diagnosis that included, but not limited to, dementia, heart disease and lung disease. On 12/8/25 at 9:45 AM Resident #3 was observed in bed, an oxygen concentrator was observed next to the resident's bed but it was not on and the resident was not receiving oxygen at the time of the observation.On 12/9/25 at 9:03 AM the resident was observed asleep in a geri-chair located next to the nursing station. No oxygen was observed being administered at this time. Review of the physician orders revealed an order, in effect since 6/24/25 for oxygen at 2 liters per minute via nasal cannula nightly; and another order, in effect since 7/25/25 for oxygen at 2 liters per minute via nasal cannula. The 7/25/25 order also included directions for staff to measure the oxygen saturation before administration. The order did not indicate the oxygen was to be given as needed or include oxygen saturation parameters.Review of the 8/3/25 Primary Care Physician note failed to reveal documentation regarding the use of oxygen for this resident.Review of the care plan revealed a plan was initiated on 12/9/25 to address the resident's need for oxygen related to diagnosis of chronic obstructive pulmonary disease (lung disease). One of the interventions was to administer oxygen per physician order. The 12/9/25 evaluation note, written by nurse #30, stated: resident uses oxygen at 2 liters continuously per physician order.Review of the treatment administration record (TAR) for December 2025 revealed staff were documenting the oxygen administration during both the day (7:00 AM to 7:00 PM) and night (7:00 PM to 7:00 AM) shifts, as well as the oxygen saturation levels each shift. All of the saturation levels for December were noted to be at or above 92%.On 12/11/25 at 10:49 AM resident was observed in bed. The resident was not receiving oxygen at the time of the observation. At 10:52 AM Nurse #17 was asked about the resident's oxygen orders. Nurse #17 responded that the order should be for oxygen as needed, that the resident does pretty well without the oxygen and that he would go speak to the physician about the order for clarification. On 12/11/25 at 4:44 PM Nurse #30 was asked about the 12/9/25 update to the care plan that stated the resident uses oxygen continuously. Nurse #30 indicated she had reviewed the TAR, which indicated oxygen was used continuously.On 12/12/25 at 9:00 AM surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure the care plan updates accurately reflected the resident's status in regard to the use of oxygen and the failure of staff to follow the physician order for oxygen.On 12/12/25 further review of the medical record revealed the 7/25/25 order for oxygen at 2 liters per minute was discontinued on 12/11/25; and a new order was put in for oxygen at 2 liters per minute via nasal cannula continuous at night and oxygen at 2 liters per minute via nasal cannula during the day to keep oxygen saturation greater than 90%.