STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215236	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	1454 Fairfield Loop Road Crownsville, MD 21032

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and medical record review, it was determined the facility failed to ensure that the resident's call light was within reach, per the individualized care plans, to allow access to assistance when needed. This was evident for 1 (#15) of 25 residents reviewed during a complaint survey.The findings include: On 9/11/25 at 9:00 AM a review of complaints 323365 and 323375 was conducted and alleged that call lights were either not answered timely or not available for the residents. On 9/11/25 at 10:20 AM observation was made of Resident #15 lying in bed. There was a small hand bell on the bed tray table. The surveyor observed a white cord attached to the wall activated call bell system. The cord was lying on the floor on the right side of Resident #15's bed. The surveyor asked why the resident had a bell on the tray table. Resident #15 stated, “so I can call the nurse.” Resident #15 stated, “most of the time I just yell because they don't come when I ring the bell.” The surveyor rang the hand bell at 10:24 AM. There was no response so at 10:28 AM the surveyor rang the call bell that was lying on the floor. The call bell was audible and at 10:30 AM geriatric nursing assistant (GNA) #13 came in the room. The surveyor informed GNA #13 that the hand bell was rung and GNA #13 stated, “I did not hear that.” GNA #13 stated that he did not know why the call bell was on the floor and out of reach of the resident. Review of Resident #15's fall's care plan documented the intervention, “keep call light in reach at all times.” On 9/17/25 at 1:00 PM the acting Director of Nursing and Regional Representative were informed of the observation.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded (Resident #4). This was evident for 1 of 3 residents reviewed for MDS assessments during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #4's medical record on 9/11/25 revealed the Resident was admitted to the facility in 2015 and has a diagnosis of dysphagia. Dysphagia is the medical term for difficulty swallowing food or liquids. Review of Resident #4's weights documented by facility staff revealed the Resident weighed 213 pounds on 9/5/24. Review of Resident #4's 10/2/24 MDS Assessment Section K Swallowing/Nutritional Status revealed Staff #4 (former Dietitian) coded in Section K0200 the Resident's weight as 213 pounds. Review of Resident #4's 3/21/25 MDS Assessment Section K Swallowing/Nutritional Status revealed Staff #4 coded in Section K0200 the Resident's weight as 191 pounds. This indicates a 22-pound weight loss or 10. 3% since the MDS Assessment 10/2/24. At that time, Staff #4 coded the Resident in Section K0300 Weight Loss (Loss of 5% or more in the last month or loss of 10% or more in last 6 months) as 0 or No. Interview with the MDS Coordinator on 9/17/25 at 10:03 AM confirmed the facility staff inaccurately coded Resident #4's Section K0300 on the 3/21/25 MDS Assessment and should have coded the Resident as Yes for Weight Loss.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on complaint, medical record review, and interview, it was determined that the facility failed to have a care plan meeting after an MDS assessment. This was evident for 1 (#13) out of 14 residents reviewed for complaints during a complaint survey.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 9/11/25 at 8:15 AM a review of complaint 323367 alleged that Resident #13 was sent back to the facility from the hospital after a 6 week stay and there was no care plan meeting held to discuss the patient's treatment and prognosis going forward. A review of Resident #13's medical record revealed on 8/10/24 Resident #13 had a change in condition and was transferred to an acute care hospital where the resident spent approximately 6 weeks. Resident #13 returned to the facility on 9/25/24. A review of Resident #13's MDS assessments revealed an MDS assessment was completed with an assessment reference date of 10/1/24. Further review of Resident #13's medical record failed to produce documentation that a care plan meeting was held after the assessment. On 9/11/25 at 12:49 PM an interview was conducted with the Social Work Director who looked through her notes and confirmed that a meeting was not held. The Social Work Director stated that a care plan meeting should have been held in October 2024 and that it fell through the cracks.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on complaint, interview, and medical record review, it was determined the facility failed to follow professional standards of practice when administering medications. This was evident for 4 (#14, #8, #17, #20) of 25 residents reviewed during a complaint survey.The findings include:The 6 rights of medication administration are the right patient, the right drug, the right does, the right route of administration, the right time, and the correct documentation. Administering medications at a time that was intended by the prescriber. Certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. Nurses should not deviate from the time by more than 1 hour to avoid consequences. Nurses must sign off that medications were given immediately after the medication was given to prevent double dosing and ensuring accuracy.1.On 9/12/25 at 11:37 AM a review of complaint 323366 alleged that Resident #14 was given Metformin (diabetic medication) after he was instructed to not take the medication for 2 days after a procedure. It was alleged that Resident #14 grabbed the pill out of the medication cup and put it aside. The complaint alleged that the nurse handed the resident the medication cup with the Metformin in it and walked out of the room without watching the resident take the medication.On 9/15/25 at 11:50 AM an interview was conducted with Resident #14 who showed the surveyor pictures of medications that were left in his/her room during the medication pass. Resident #14 also stated the nurse left an insulin pen in his/her room, and it was the name of another resident. Resident #14 stated that Staff #10 makes medication mistakes and that she gave him/her the Metformin when she was supposed to hold it. Resident #14 stated, I looked in the cup and pulled the pill out. I then went and showed them that she was giving me a medication that was supposed to be held. They will leave the medications in my room. Staff #14 also complained that medications were not passed out timely and were often late.On 9/15/25 at 1:37 PM a review of an employee corrective action form dated 10/25/25 documented that Staff #10 was written up for attempting to administer Metformin that was not scheduled to be given and failing to follow a physician's order. A second corrective action form for Staff #10 documented that on 4/19/25 Staff #10 failed to follow the 5 rights of medication administration by administering a different patient's insulin to another resident, which was Resident #14. 2. Review of residents' medication administration records (MARs) revealed a pattern of charting late when medications were given. It was not known if the medication was given late or if the nurses signed of later in the shift that the medication was given.a. On 9/10/25 at 9:37 AM a review of Resident #8's medical record revealed the following:The medication Gabapentin for neuropathy was ordered to be administered every 12 hours at 9 AM and 9 PM. Review of the June 2025 MAR documented on 6/20/25 the 9 AM dose was signed off at 3:03 PM, the 6/22/25 at 9 AM dose was signed off at 11:26 AM.The medication Hydralazine 25 mg (blood pressure and heart failure medication) was to be administered at 9 AM, 2 PM, and 9 PM. Review of the June 2025 MAR documented the 6/20/25 at 9 AM dose was signed off at 3:03 PM and the 2:00 PM dose was signed off at 3:07 PM. On 6/21/25 the 9 AM dose signed off at 11:11 AM and the 9:00 PM signed off at 10:34 PM. The 6/22/25 at 9 AM dose was signed off at 11:26 AM.b. Resident #17's medical record was reviewed and revealed Acetaminophen was to be given at 6 AM, 2 PM, and 9 PM. On 8/9/25 the 2:00 PM dose was signed off at 6:34 PM, the 8/19/25 at 6 AM dose was signed off at 7:50 AM, and the 9/1/25 at 2 PM dose was signed off at 6:02 PM.The medication Aspirin that was to be administered at 9 AM, on 8/1/25 and 8/25/25 was signed off at 12:44 PM and the 8/26/25 at 9 AM was signed off at 11:09 AM. In September 2025, the 9 AM dose was signed off at 12:04 PM on 9/1/25, on 9/7/25 at 12:42 PM, and on 9/10/25 at 1:53 PM.The medication Eliquis (blood thinner) was to be administered at 9 AM and 9 PM. On 8/1/25 and 8/25/25 the Eliquis signed off at 12:44 PM and the 8/26/25 at 9 AM dose signed off at 11:09 AM. In September 2025, the 9 AM dose was signed off at 12:05 PM on 9/1/25, on 9/7/25 at 12:42 PM, and on 9/10/25 at 1:54 PM.The medication phenytoin (anti-seizure) medication was to be administered at 6 AM, 2 PM, and 9 PM. The 2 PM dose signed off at 6:34 PM and the 6 AM dose signed off at 7:50 AM. In September 2025 the 9/1 at 2 PM signed off at 6:05 PM.c. Resident #20's medical record was reviewed and revealed the medication Amlodipine (blood pressure) was to be given at 9 AM every day. The 9 AM dose was signed off on 9/1 at 12:22 PM, 9/3 at 11:58 AM, 9/7 at 12:31 PM, 9/10 at 4:13 PM, and 9/15 at 11:32 AM. The prescription mouthwash chlorhexidine gluconate was to be administered 3 times a day at 9 AM, 2 PM, and 9 PM. The 9/1 at 9AM dose was signed off at 12:16 PM, the 2 PM dose at 7:51 PM, the 9/3 at 9 AM dose at 12:11 PM, the 9/7 at 9 AM dose at 12:31 PM, the 9/10 at 9 AM dose at 3:56 PM and the 2 PM dose at 3:19 PM, and the 9/15 at 9 AM dose at 11:32 AM.The medication Eliquis (blood thinner) was to be

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on complaint, medical record review, observation, and interview, it was determined the facility staff failed to provide showers twice weekly to residents. This was evident for 5 (#19, #13, #17, #24, #15) of 25 residents reviewed during a complaint survey. The findings include: 1.On 9/12/25 at 9:04 AM a review of complaint 323357 alleged that Resident #19 was being neglected at the facility. On 9/12/25 at 9:04 AM a review of Resident #19's medical record revealed the resident was admitted to the facility in February 2024 with diagnoses that included but were not limited to systemic lupus erythematosus, chronic pain, heart failure, muscle wasting, and a cognitive communication deficit.Review of Resident #19's physician's orders documented the resident could shower on Tuesdays and Thursdays in the evening.Further review of Resident #19's medical record revealed the facility staff assessed the Resident on 3/23/24 to require substantial/maximal assistance for showering and bathing. Review of geriatric nursing assistant (GNA) shower/bathing documentation revealed in April and May 2024 the resident did not receive a shower, only bed baths, and in June 2024 only 1 shower was documented as given. There was no documentation of resident refusals for showers. On 9/17/25 at 11:14 AM an interview was conducted with the Assistant Director of Nursing (ADON) and RN unit manager; Staff #26 who stated the expectation was that all residents are to receive at least 2 showers a week and the staff are to document if the resident refuses. 2. On 9/11/25 at 8:15 AM complaint 323356 was reviewed and alleged Resident #13 was not clean, and his/her hair was dirty.Review of GNA bathing documentation revealed Resident #13 went from 6/18/24 to 7/1/24, which was 12 days without a shower and from 7/15/24 to 7/22/24, which was 7 days. It was documented that the resident received bed baths during that time. 3. On 9/10/25 at 12:55 PM complaint 323362 was reviewed and alleged Resident #17 had not received showers.Review of Resident #17's medical record revealed the resident was admitted to the facility in May 2021 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominate side, chronic pain syndrome and diabetes mellitus.Review of Resident #17's physician's orders documented the resident could shower on Monday and Fridays in the evening.Further review of Resident #17's medical record revealed the facility staff assessed the Resident on 7/30/25 to be totally dependent on staff for showering and bathing. Review of GNA shower/bathing documentation revealed in June 2025, July 2025, and August 2025 the resident did not receive a shower, only bed baths. There was no documentation of resident refusals for showers. On 9/10/25 at 12:38 PM Resident #17's resident representative (RP) was interviewed and stated that if he calls the resident, the resident will agree to a shower and will not refuse. On 9/11/25 at 10:40 AM an interview was conducted with Geriatric Nursing Assistant (GNA) #22 who stated, most days we work with 3 GNAs which means we have 16 to 17 residents each. GNA #22 was asked how often she changed residents in a shift she said once. When she was asked again she confirmed that she only had time to change residents once per shift. GNA #22 stated, when you have to get people up and change them it is a lot. GNA #22 stated that there were a couple of times when there were only 2 GNAs and they would have 27 patients. GNA #22 stated that it happened on a weekend in June/July.On 9/12/25 at 12:51 PM an interview was conducted with Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA) and Unit Manager, Staff #26. Informed them about residents not receiving showers. They said Resident #17 would refuse; however, they acknowledged that there was no documentation that the resident refused. They thought that since it was in the care plan that was sufficient. The 3 of them were informed that the staff stated they don't have time to call the son to encourage the resident to take a shower. They all stated that was unacceptable.On 9/16/25 at 10:07 AM an interview was conducted with Resident #17. Resident #17 stated that he/she does not refuse showers. Resident #17 stated when it is cold he/she gets in extreme pain because he/she is paralyzed on the left side of the body. Resident #17 stated he/she had a shower for the first time a week ago and now they are coming in to ask him/her. Resident #17 also stated that he/she usually gets changed once on day shift. Resident #17 stated, they are supposed to be turning me more frequently and they don't do that. 4. On 9/12/25 at 12:25 PM with the ADON, observation was made of Resident #24 sitting in a wheelchair in the dining room. The ADON wheeled the resident to the activity room for an interview with the surveyor. Resident #24 smelled of feces. Observation was made of Resident #24's hair which had dried food caked in the hair and the hair was disheveled.On 9/12/25 at 12:45 PM a review of Resident #24's GNA documentation for showers from 9/1/25 to 9/11/25 revealed the resident had not received a shower and had 3 complete bed baths and 4 partial bed baths in 11 days. On 9/12/25 at 12:51

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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 complaint, medical record review, and staff interview, it was determined the facility staff failed to provide wound care treatment as prescribed by the physician. This was evident for 2 (#19, #14) of 4 residents reviewed for wound care during a complaint survey.The findings include:1.On 9/12/25 at 9:04 AM a review of complaint 323357 alleged Resident #19 had a wound on the left leg that had become infected and did not have proper wound care.Review of Resident #19's medical record revealed the resident was admitted to the facility in February 2024 with diagnoses that included but were not limited to systemic lupus erythematosus and history of venous thrombosis and embolism.Review of a 5/29/24 wound management note documented a venous wound of the left calf with undetermined thickness. The treatment plan was, skin prep apply every shift (3 times a day) for 30 days.Review of a 6/5/24 wound management note documented the treatment plan was, silver sulfadiazine apply once daily for 30 days; alginate calcium apply once daily for 30 days.Review of a 6/12/25 wound management note documented the treatment plan was, leptospermum honey apply once daily for 30 days; alginate calcium apply once daily for 30 days. Secondary dressing, gauze island with border apply once daily for 30 days. Review of a 6/19/25 wound management note documented the treatment plan was, betadine apply 3 times per week for 30 days.Review of a 6/26/25 wound management note documented the treatment plan was, betadine apply 3 times per week for 23 days. Review of Resident #19's June 2024 Treatment Administration Record (TAR) documented the treatment, skin prep to left calf 3 times per day from 6/1/24 to 6/14/24 on day shift. There was no documentation as to why the treatment only went to 6/14/24. There was no treatment to the left calf from 6/14/24 until 6/19/24, when the resident was sent to the hospital.On 9/17/25 at 10:45 AM the wound and treatment was discussed with Assistant Director of Nursing (ADON) and the RN unit manager, (Staff #26). It was discussed that skin prep to the left calf 3 times per day was written on 5/29/24 but on the 6/5/24 visit the treatment was changed. The ADON and Staff #26 stated, we go around with the wound doctor and then staple the paper for the nurses and check the treatments. It is like we have to babysit the nurses.On 9/17/25 at 11:14 AM the ADON and RN unit manager came back to the surveyor and confirmed that the treatment change effective 6/5/25 was not carried out by the nurses.2.On 9/12/25 at 11:37 AM a review of complaint 323366 alleged that the wound doctor came every Wednesday to see Resident #14 and there were orders for the nurses to clean and change the bandage every day but that never took place. The bandage was on the right, first toe. This allegation occurred in October 2024.A review of Resident #14's medical record revealed Resident #14 was admitted to the facility in November 2023 with diagnoses that included polyneuropathies, chronic pain, and type 2 diabetes mellitus.Review of Resident #14's wound care note dated 9/2/25 documented the resident had a diabetic wound of the right, first toe that was full thickness that had a duration of greater than 384 days. Review of Resident #14's October 2024 Treatment Administration Record (TAR) documented the physician's order, cleanse right big toe with NSS (normal saline solution), apply Calcium alginate and cover with dry dressing daily. The order was from 10/10/24 to 11/1/24. The nurses signed off every day that the treatment was done as evidenced by their initials in the box on the TAR.There was a second order on the TAR that documented, mupirocin ointment 2% to be administered topically once a day to the right first toe diabetes callous: cleanse with NSS, apply Bactroban and Calium alginate and cover with dry dressing daily. The order was from 9/11/24 to 11/1/24. The nurses signed off every day that the treatment was done as evidenced by their initials in the box on the TAR.On 9/16/25 at 12:55 PM the TAR and both orders were reviewed with the ADON. The ADON confirmed that the treatment was not done correctly and that the nurses failed to cancel out the first treatment before they entered the second treatment, therefore they signed off that they were doing both treatments, so it was unknown if they were just signing it off or doing both.On 9/17/25 at 1:00 PM the concerns related to wound care were expressed to the Director of Nursing and the Regional Representative.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility failed to provide treatment/services to prevent/heal pressures ulcers. This was evident for 1 (#7) 3 residents reviewed for pressure ulcers during a complaint survey.The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). On 9/16/25 at 11:30 AM a review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses that included stage IV cancer with metastases to the brain. A 2/13/25 at 01:00 AM nursing note documented that Resident #7 was admitted with, sacral ulcer noted measuring 3 x 2 cm, unstageable with slough.On 2/19/25 a wound care note documented the sacral ulcer was a Stage 4 pressure wound full thickness, and the treatment plan was, Leptospermum honey apply once daily for 30 days; Alginate calcium apply once daily for 30 days Secondary Dressing gauze island w/bdr (border) apply once daily for 30 days. Resident #7 was seen again by the wound care team on 2/26/25 and 3/6/25 with the same dressing treatment.Review of Resident #7's February and March 2025 Treatment Administration Record (TAR) documented the treatment: Cleanse sacral/coccyx wound with NSS, followed by mepilex and cover with dressing. It was signed off from 2/13/25 to 2/28/25 and 3/1/25 to 3/5/25. The facility failed to follow the wound care team's dressing orders.On 9/16/25 at 1:30 PM an interview was conducted with the Assistant Director of Nursing (ADON) and the RN unit manager (Staff #26). The orders and the wound care notes were reviewed with them and they both confirmed that the nurses failed to relay the orders from the wound care team and put them into the computer.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview, the facility staff failed to follow recommendations from the dietitian timely and notify the Resident's physician or nurse practitioner of the Resident's continued weight loss (Resident #4). This was evident for 1 of 3 residents reviewed for nutritional status during a complaint survey. The findings include: Review of Resident #4's medical record on 9/11/25 revealed the Resident was admitted to the facility in 2015 and has a diagnosis of dysphagia. Dysphagia is the medical term for difficulty swallowing food or liquids. Review of Resident #4's weights documented by facility staff revealed the Resident weighed 213 pounds on 9/5/24. Further review of Resident #4's medical record revealed Staff #36 (former Dietitian) saw the Resident on 2/4/25 for weight loss and documented the Resident's weight as 200.8 pounds. At that time the Dietitian ordered Med Pass 2.0 twice a day for 30 days. Med Pass is a fortified nutritional shake that provides a way to supplement calories and protein. Further review of Resident #4's medical record revealed a Nurse Practitioner's (Staff #37) note on 2/10/25 that stated Nursing reports patient had a 12-pound weight loss in a month and Plan for weight loss: Nutrition consulted. Supplements. Follow up with dentist to have dentures re-fitted. Monitor Weights. The Resident was not seen by the Dietitian again until 3/6/25, 3 1/2 weeks later and documented the Resident's weight as 190.9 pounds. At that time the Dietitian documented: Unplanned weight loss. Recommendation: New order for Med Pass three times a day, requesting MD consider order of medication with appetite stimulating side effect. Review of Resident #4's physician orders revealed the Resident was not ordered an appetite stimulant medication until 3/26/25, 20 days later. Further review of Resident #4's medical record revealed although Staff #31 (current Dietitian) had seen the Resident monthly no further interventions had been put in place including notification to the Resident's physician. Staff #31 documented on 8/9/25 the Resident's weight was 178 pounds. That is a loss of 35 pounds since 9/5/24. Review of all physician and nurse practitioner notes through 8/18/25 revealed no documentation the providers were aware of Resident #4's continued weight loss since 3/26/25. Interview with Resident #4's Nurse Practitioner (Staff #35) on 9/17/25 at 9:00 AM, Staff #35 was not aware of Resident #4's weight loss of 35 pounds since September 2024 and stated usually nursing staff would make her aware of a Resident's weight loss. Interview with the Assistant Director of Nursing on 9/17/25 at 9:45 AM confirmed the facility staff failed to timely order an appetite stimulant and notify Resident #4's physician or nurse practitioner of the Resident's continued weight loss.

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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. Based on medical record review and facility staff interviews, it was determined that the facility staff failed to ensure that either the attending physician, physician assistant or nurse practitioner visited residents at the required intervals of every 60 days (Resident #4). This finding was evident in 1 of 3 residents reviewed for physician visits during a complaint survey. The findings include: Review of Resident #4's medical record on 9/11/25 revealed the Resident was admitted to the facility in 2015 and transferred to the hospital on 9/6/25. Review of Resident #4's physician, physician assistant and nurse practitioner notes from January 2025 until 9/6/25 revealed the Resident was not seen from 4/25/25 until 7/11/25 for a total of 76 days. During interview with Staff #35 on 9/17/25 at 9:00 AM, Staff #35 stated she could not see any physician, physician assistant or nurse practitioner notes from 4/25/25 until 7/11/25. Interview with the Assistant Director of Nursing on 9/17/25 at 9:45 AM confirmed Resident #4 has no documented visits from a physician, physician assistant or nurse practitioner from 4/25/25 until 7/11/25.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview it was determined that the facility failed to post the nurse staffing data at the beginning of each shift and failed to post the total number and the actual hours worked by nursing staff. This was evident upon entry to the facility in the lobby area, on 2 of 2 nursing units, and for the first two days of the survey.The findings include. On 9/10/25 at 8:00 AM, upon entry to the facility's lobby, there was no signage of nursing staff that were working in the building displayed anywhere in the lobby or hallways leading to the nursing units. Observation was made on the 200 hallway of a white, dry erase board that listed the names of 2 nurses and 3 GNAs (geriatric nursing assistants). The date written on the board was 9/3/25. There was no staffing posted anywhere on the unit. Observation was made of the 100 hallway of a white, dry erase board that listed the names of nurses and GNAs, however there were no nursing hours posted for the day. On 9/11/25 at 8:30 AM a second observation was made of the facility's lobby and both nursing units. There were no postings of the total number and the actual hours worked by registered nurses, licensed practical nurses, or certified nurse aides. On 9/11/25 at 12:44 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON confirmed that there were no hours posted. The ADON stated that the scheduler had been out for at least the past 2 weeks, and no one had posted the staffing. The Human Resources Director, Staff #23 confirmed that she was supposed to post the nursing hours while the scheduler was not in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with staff, it was determined the facility failed to timely provide medication to meet the needs of the residents. This was evident for 1 (#8) of 25 residents reviewed during a complaint survey. The findings include: On 9/10/25 at 9:37 AM Resident #8's medical record was reviewed and revealed Resident #8 was admitted to the facility on [DATE] from an acute care facility for rehabilitation. Resident #8's diagnoses included but were not limited to paralytic syndrome following cerebral infarction, pain, hypertension, dementia, restless leg syndrome, neuralgia/neuritis, and a sacral ulcer. Review of June 2025 physician's orders revealed a 6/19/25 order for Tramadol 50 mg. to be given 4 times a day at 9:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM was written. Tramadol is a strong opioid pain medication prescribed for the treatment of moderate to moderately severe pain in adults. Review of Resident #8's June 2025 Medication Administration Record (MAR) documented the Tramadol was not available on 6/20/25 at 9:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, on 6/21/25 at 4:00 PM and 9:00 PM, on 6/22/25 at 9:00 AM, 12:00 PM, 4:00 PM, 9:00 PM and at 9:00 AM on 6/23/25. On 9/17/25 at 8:50 AM an interview was conducted with the Assistant Director of Nursing (ADON) and Staff #26 (RN unit manager). The June 2025 MAR was reviewed with them for Resident #8, and they were asked how long it should have taken for the Tramadol to be delivered to the facility. The ADON and Staff #26 stated there was no reason that the nurses could not have called the pharmacy to get the medication for the resident. They said it should have been to the facility within 4 hours. On 9/17/25 at 9:13 AM Staff #33 (LPN) was interviewed and asked the process for obtaining a narcotic medication. Staff #33 stated, we have to call the doctor, and the doctor has to call the pharmacy and get a code and then they will deliver it. Staff #33 stated the resident's spouse did not want the resident to have the medication because the resident would be too drowsy and that's what they did at the hospital. The surveyor asked Staff #33 if she called the doctor when the medication was not available and she said, I think I did. I may have forgotten to document that. There was no documentation that Staff #3 called the physician to request the medication.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to monitor a resident's blood pressure when there were physician ordered blood pressure parameters. This was evident for 1 (#8) of 25 residents reviewed during a complaint survey.The findings include: On 9/10/25 at 9:37 AM Resident #8's medical record was reviewed and revealed Resident #8 was admitted to the facility on [DATE] from an acute care facility for rehabilitation. Resident #8's diagnoses included but were not limited to paralytic syndrome following cerebral infarction, pain, hypertension, dementia, restless leg syndrome, neuralgia/neuritis, and a sacral ulcer. Review of June 2025 physician's orders revealed there were 3 medications ordered for blood pressure, which were Isosorbide Monotrate 30 mg., Lisinopril 20 mg., which were to be administered at 9 AM once a day and hydralazine 25 mg. which was to be administered 3 times a day at 9 AM, 2 PM, and 9 PM. All 3 medications had physician ordered parameters to hold for a blood pressure reading of less than 100. Review of Resident #8's June 2025 Medication Administration Record (MAR) documented that the blood pressure was being monitored at 9 AM as evidenced by the blood pressure reading and the nurse's initials next to the Lisinopril. There were no blood pressures documented next to the Hydralazine for the 2 PM dose and the 9 PM dose. Review of the vital sign section of the electronic medical record was inconsistent for taking blood pressures at 2 PM and 9 PM, when the other 2 doses of Hydralazine were administered. On 9/17/25 at 8:50 AM an interview was conducted with the RN unit manager, Staff #26 and the Assistant Director of Nursing (ADON). The MAR was reviewed with them and the blood pressure medications with parameters. The ADON and Staff #26 stated that whoever put the order in should have put in a space for the blood pressure to be recorded for all medications that required a blood pressure reading. They confirmed the surveyor's findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, observation, staff interview, and documentation review, it was determined that facility staff failed to keep medication carts locked when unattended, failed to date medications when opened, and refrigerate medication that required refrigeration. This was evident on 1 of 2 nursing units observed during random observations made during a complaint survey. On 9/10/25 at 8:30 AM a review of complaint 323371 was conducted and alleged that on the weekends medication carts were left unlocked all day.On 9/11/25 at 10:55 AM observation was made of an unlocked and unattended medication cart sitting in the 200 hallway outside of room [ROOM NUMBER]. The surveyor heard the nurse in room [ROOM NUMBER], however the nurse (staff #20) had her back to the door and was standing up towards the head of the resident's bed and the medication cart was not in her sight. The surveyor was able to open the cart and observed the top drawer with a cup of pre-poured medications. There were 12 whole pills and 2 half pills in the cup. Observation was made in the medication cart of Resident #22's opened Trelegy Ellipta inhaler that was not dated when opened. According to the manufacturer's instructions the medication should be discarded 6 weeks after opening.Observation was made in the medication cart of Resident #21's opened Humalog insulin that was not dated when opened. There was also an opened Lantus pen for Resident #21 with no date opened written on the pen. According to the manufacturer's instructions insulin is only good for 28 days once opened. Observation was made in the medication cart of Resident #23's opened Humalog insulin that was not dated when opened. There were other insulin pens for Resident #23 that had a refrigerate sticker on the pens, however the pens were not refrigerated.Staff #20 walked out of the room and questioned why the surveyor was going through the medication cart. The surveyor informed Staff #20 that the medication cart was left unlocked and unattended. Staff #20 was asked about the medications that were pre-poured. Staff #20 stated the resident was unavailable due to being in therapy. There was no name written on the medication cup. Review of the Medication Storage Policy that was given to the surveyor from the Assistant Director of Nursing (ADON) on 9/17/25 at 11:55 AM revealed procedure number 2, the medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members. Procedure number 7 documented, once any multi-dose packaged medication or biological is opened, nursing will mark multi-dose products (e.g. inhalers, insulin, ophthalmics, otics and the like) with the date opened and follow manufacturer/supplier guidelines with respect to expiration dates.On 9/16/25 at 2:20 PM the Director of Nursing (DON) was informed of the medication concerns.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on medical record review and interview, the facility staff failed to obtain follow up dental services for a resident (Resident #4). This was evident for 1 out of 3 residents reviewed for dental services during a complaint survey. The findings include: Review of Resident #4's medical record on 9/11/25 revealed the Resident was admitted to the facility in 2015 and had a diagnosis of dysphagia. Dysphagia is the medical term for difficulty swallowing food or liquids. Further review of Resident #4's medical record revealed a Nurse Practitioner (NP)'s note on 2/10/25 that stated, Nursing reports patient had a 12 lb weight loss in a month. Per patient, he/she reports not having proper fitting dentures. Spoke with nursing manager regarding this. Informed that nurse manager will follow up with dentist regarding this to have patient refitted for dentures. Further review of Resident #4's medical record revealed the Resident was examined by the Registered Dental Hygienist (RDH) on 6/24/25. The RDH documented, Patient has pain on #29 and also wants dentures. Dentist will be seeing patient 7/9/25, advised patient. Further review of Resident #4's medical record revealed the Resident was not seen by the Dentist on 7/9/25. During interview with the Assistant Director of Nursing (ADON) on 9/17/25 at 11:10 AM, the ADON confirmed Resident was not seen by the Dentist on 7/9/25 and as of 9/17/25 the Resident has not been seen by the Dentist.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident received their prescribed diet with the prescribed consistency. This was evident for 2 (#6, #9) of 8 residents observed in the dining room during a complaint survey.The findings include:On 9/11/25 at 1:40 PM observation was made of 8 residents sitting in the dining room eating lunch. The surveyor walked around to each table to ask the residents how their food was. Resident #6 complained that the food was not good. Review of Resident #6's lunch tray ticket documented the resident had a house, mechanical soft, ground, minced moist diet. The first entree was ground chicken parmesan. Observation of the food on Resident #6's plate revealed cubed chicken parmesan. The meat was not ground.Observation was made of Resident #9's lunch tray ticket. It was documented that Resident #9 had a house mechanical soft ground meat diet. The first entree on the tray ticket was, ground alternate entree. The meat on the plate was in chunks and was not ground.On 9/11/25 at 1:40 PM Staff #25 was sitting in the dining room while the residents were eating. The surveyor pointed out to Staff #25 that both residents had meat on their plates that was not ground. Staff #25 stated, well it is moist. That is the way it always is. At that time the surveyor requested to see the Food Service Director, Staff #21. Staff #21 came out of the kitchen and reviewed the tray tickets along with the plates of food with the surveyor. Staff #21 confirmed that their meats should have been ground. Staff #21 called Staff #40, the cook, out of the kitchen and she confirmed the findings. Staff #21 stated, I can't keep my eye on everyone that works in the kitchen. This will need follow-up.Review of Resident #9's medical record revealed at risk on the profile for, choking, swallowing, aspiration, weight loss/gain, dehydration that was written on 7/6/23. A 12/10/24 dietary order documented, diet - house, consistency - mechanical soft with special instructions: GROUND MEAT, may have soft bread prepared with spread (e.g. butter, jam).Review of Resident #6's medical record revealed a general order, at risk for, choking, swallowing, aspiration, weight loss/gain, dehydration that was written on 3/25/25. A 4/3/25 dietary order documented, house diet, mechanical soft, ground, minced moist meat dysphagia following cerebral infarction.On 9/17/25 at 1:00 PM the concern was discussed with the Director of Nursing and Regional Representative.

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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. Based on complaint, medical record review, and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (#19) of 25 residents reviewed during a complaint survey.The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. On 9/12/25 at 9:04 AM a review of complaint 323357 alleged that Resident #19 was being neglected at the facility. The complaint alleged that Resident #19 was often not fed due to short staffing and the resident's spouse had to visit to feed the resident to ensure the resident was fed.On 9/12/25 at 9:04 AM a review of Resident #19's medical record revealed the resident was admitted to the facility in February 2024 with diagnoses that included but were not limited to systemic lupus erythematosus, chronic pain, heart failure, muscle wasting, and a cognitive communication deficit.A review of the geriatric nursing assistant (GNA) feeding documentation revealed the GNAs would document the date, time, the meal, the amount consumed, and their name.In June 2024 there was missing documentation for the following days: For breakfast and lunch: 6/2, 6/6, 6/8, 6/10, 6/11, 6/12, 6/14, 6/16In May 2024 there was missing documentation for the following days:For dinner: 5/2, 5/9, 5/17, 5/21 For breakfast and lunch: 5/5, 5/10, 5/15, 5/22, 5/24, 5/27, 5/29 For breakfast, lunch, and dinner: 5/6In April 2024 there was missing documentation for the following days: For breakfast, lunch, and dinner 4/8For breakfast and lunch: 4/13, 4/15, 4/17, 4/20, 4/21For dinner: 4/18, 4/24, 4/26 On 9/17/25 at 11:14 AM the findings were discussed with the Assistant Director of Nursing (ADON) and Staff #26 RN unit manager. It was discussed that the amount of food the resident consumed could not be validated as the documentation was incomplete. The ADON and Staff #26 agreed with the surveyor's findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility failed to arrange Hospice services for a resident who requested the services. This was evident for 1 (#7) of 25 residents reviewed during a complaint survey.The findings include:On 9/16/25 at 11:30 AM a review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE] from an acute care facility.A 2/12/25 at 22:00 PM nursing note documented that Resident #7's sister stated Resident #7 has had cancer for 2 years and it had spread to the resident's brain. The sister stated Resident #7 had 10 rounds of radiation and it was not successful. The sister stated she talked to a hospice nurse at the hospital and did not know if Resident #7 was now admitted to the facility for rehabilitation, palliative or comfort care.A 2/15/25 at 13:00 PM nursing note documented, Pt. and family states pt. wants hospice services. Pt stated [he/she] is tired and wants to go peacefully and comfortably r/t 2 yr. battle. Pt. recently completed 10 rounds of radiation, not successful. Pt. states [he/she] does not have an appetite. Made PCP (primary care physician) aware. PCP states contact hospice.There was no documentation after the 2/15/25 nursing note until 2/27/25 when the resident was seen for follow-up for pain management. Resident #7 was complaining of pain, 10 out of 10 on the pain scale in bilateral hips and it was not controlled by Tylenol. The physician wrote a script for stronger pain medication and an order for palliative care consultation.Resident #7 was discharged home on 3/5/25 with Hospice services to be started when the resident arrived home.Review of physician orders in Resident #7's medical record failed to produce a verbal order for Hospice services on 2/15/25.On 9/16/25 at 12:18 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was asked what the process was if a resident or their family wanted Hospice services. The ADON stated that they communicate to social work, and they will reach out to Hospice and usually it would take a few days to get here. On 9/16/25 at 12:30 PM an interview was conducted with the Director of Social Services, Staff #24. Staff #24 initially stated she did not remember the resident. Staff #24 called Hospice and spoke to a staff member who stated the resident initially refused Hospice services and they were cancelled on 2/6/25 but was signed in again on Hospice 3/5/25. It was noted that the resident had not been admitted to the facility until 2/12/25, therefore the services were cancelled prior to admission.Staff #24 was asked what the process was for when a resident requested to be on Hospice. Staff #24 stated, the nurse will give the order to the social work, however now the physician comes directly to me and gives me the order. Staff #24 was asked if there had been an issue with receiving Hospice orders and that was why the physician was coming directly to her. Staff #24 stated, sometimes they would bring the order to me and sometimes they would not. Now the physician brings them to me directly.On 9/16/25 at 1:30 PM an interview was conducted with the ADON and Staff #26. They both said they read notes every day and that Social Work should have gotten the Hospice consult. On 9/17/25 at 1:00 PM the Director of Nursing and the Regional Representative were informed of the concern.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, observations, and interview, it was determined the facility failed to maintain a working call bell system. This was evident for 1 (Capitol) of 2 nursing units observed during a complaint survey.The findings include:On 9/16/25 at 10:30 AM a review of complaint 323371 was conducted and it was alleged that the family pushed the call bell button in room [ROOM NUMBER]-A, which was on the Capitol unit, and the light did not illuminate in the hall. It was alleged that the family was told that the call bell was not in working order at the desk or the volume was turned down. On 9/16/25 at 10:45 AM the surveyor went in room [ROOM NUMBER] A. The resident was not in the room at that time. The surveyor pushed the call bell button and walked outside in the hallway. There was no audible sound in the hallway, however the light was illuminated over the doorway. The surveyor went back into room [ROOM NUMBER] and went to bed B and asked permission from the resident to activate the call bell. The surveyor pushed the call light button. The light illuminated outside in the hallway but was not audible.At that time Staff #10 was in the hallway and the surveyor informed her that the call bell could not be heard. Staff #10 went into room [ROOM NUMBER] and came back out and confirmed that she could not hear the call bell sounding.The surveyor then went into rooms 203, 205, and room [ROOM NUMBER]. The call bells were activated in each room. There was no audible sound, however the over-the-door lights were lit.On 9/16/25 at 10:45 AM an interview was conducted with Resident #25 in room [ROOM NUMBER]. Resident #25 was holding the white call bell cord in the right hand and kept pushing the button. Resident #25 stated, I keep holding and pressing the call button and I did not know it was not working. No one has come in here. There was a hand bell observed on the bed tray table. Resident #25 rang that bell, but it could not be heard at the nurse's station.On 9/16/25 at 10:57 AM the surveyor asked Staff #29, who was at the nurse's station, if he heard the bells ringing. Staff #29 said he did not hear them ringing. Staff #10 was in the hall and confirmed she could not hear anything.On 9/16/25 at 11:12 AM the Director of Maintenance came to the unit and went in the nurse's station and stated that the speaker was turned off. On the computer screen was a speaker icon and he showed how it had been turned off as evidenced by a slash through the speaker icon.On 9/16/25 at 11:14 AM the Assistant Director of Nursing (ADON) and Staff #26 (RN unit manager) came to the unit and denied that staff could turn off the call bells. They stated they needed to figure out why the sound went off so it could be fixed.On 9/16/25 at 11:30 call bells could be heard ringing on the Capitol unit after surveyor intervention.On 9/17/25 at 1:00 PM the Director of Nursing (DON) and the Regional Representative were informed of the concern at the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215236	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	1454 Fairfield Loop Road Crownsville, MD 21032

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on complaint, observations, and interview, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, visitors, and staff. This was evident in 2 of 2 outside areas during a complaint survey.The findings include. On 9/11/25 at 8:15 AM a review of complaint 323356 alleged that the resident's outside area is a disgrace. Wooden planter boxes falling apart and crumbling concrete. On 9/11/25 at 12:34 PM observation was made with the Maintenance Director (staff #4) of the courtyard where the residents were permitted to smoke. The wooden flower bed planter boxes were grayish colored old wooden boards that were dilapidated and falling apart. There were multiple concrete areas on the patio that had broken, crumbled, and chipped pieces of concrete that made the area uneven to walk on and there were multiple sizes of rocks scattered throughout the area. Staff #4 stated that the flower beds had not been used in 6 to 7 years, and he said a couple of people have wanted to come in and fix them. Staff #4 stated that the flower bed planter boxes belonged to the activity department. Staff #4 was shown the concrete areas and stated, I can't fix that. We will have to bring in a contractor.On 9/11/25 at 12:44 PM the Nursing Home Administrator (NHA) was asked to come out to the courtyard with the surveyor. The NHA confirmed that the area was not attractive and concurred with the condition of the concrete.The surveyor and NHA then proceeded to go out to the courtyard on the other side of the dining room where residents and visitors could go to enjoy the outside. Observation was made of a white, bunched up, wet moldy sheet sitting on a window radiator and there were 2 boards propped up against the brick wall next to the radiator. That area was adjacent to where residents and visitors could sit at a table. There was a large, thick hose on the top of the picnic table and there were dilapidated bird houses barely hanging on a post. The NHA acknowledged the concerns.