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	03/23/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on medical record review and interview, it was determined the facility failed to obtain consent from a resident's representative for a change in treatment. This was evident for 1 (Resident #5) of 6 residents reviewed during a complaint survey. The findings include:Review of Resident #5's medical record on 3/19/26 revealed the Resident was admitted to the facility in October 2025 with a diagnosis to include dementia with psychotic disturbance.Further review of Resident #5's medical record revealed the Resident was assessed by facility staff on 10/29/25 to have a BIMS (Brief Interview for Mental Status) of 6 out of 15 indicating severe cognitive impairment.Review of Resident #5's physician orders revealed on 12/23/25 Staff #16 ordered the Resident to receive Seroquel 25 mg twice a day.Seroquel is an antipsychotic medication used in the treatment of schizophrenia, bipolar disorder and major depressive disorder.Review of a physician note (Staff #16) on 12/26/2025 revealed Staff #16 documented: Patient agitated and not tolerating nursing or therapy care. No clear triggering etiology identified at this time. Staff #16 documented under plan: Will start short course of Seroquel for mood stabilization.Review of Resident #5's paper and electronic medical record revealed no consent was obtained for the administration of Seroquel.Review of Resident #5's December 2025 and January 2026 Medication Administration Records revealed Resident #5 received Seroquel beginning 12/23/25 at 9:00 PM and then twice daily until 1/27/26 when it was placed on hold for 7 days. Review of Resident #5's February 2026 Medication Administration Record revealed the Resident's Seroquel 25 mg was restarted on 2/4/26 at 9:00 AM until 2/6/26 at 9:00 AM.Interview with Staff #16 on 3/20/26 at 12:44 PM confirmed the facility staff failed to obtain consent for the administration of Seroquel to Resident #5.Interview with the Director of Nursing on 3/23/26 at 12:30 PM confirmed the facility staff failed to obtain consent from Resident #5's representative for the administration of Seroquel.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, observation of resident rooms, and interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. This was evident for 1 (Resident #3) of 5 resident rooms observed during a complaint survey.The findings include: On 3/17/26 a review of complaint 2713635 from January 2026 alleged Resident #3's room had a fruit fly infestation. Observation of Resident #3's room on 3/17/26 at 12:24 PM revealed a few fruit flies flying around the Resident's room. The Surveyor observed behind the Resident's door on a bedside table a food tray with a tray ticket from 3/16/25 dinner. On the tray the Surveyor observed what appeared to be pasta and carrots, milk and ice cream containers. The Surveyor also observed behind the Resident's door a food tray with a tray ticket from 3/17/26 breakfast with food crumbs on it. Resident #3 was observed sitting in his/her chair with another bedside table in front of him/her. This bedside table was visibly dirty. Resident's drawers were also noted to be visibly dirty. Debris was noted on the floor by the Resident's window. Two peanut butter jars were observed on the Resident's shelves with peanut butter on the outside of the jars. The Resident's toilet was noted to be constantly running. During interview with Resident #3 at that time, the Resident was asked if he/she was willing to have housekeeping come in his/her room to clean up his/her room, remove the food trays and if the peanut butter jars could be placed in a sealed container. The Resident stated yes. The Surveyor returned to Resident #3's room on 3/17/26 at 12:33 PM with the Director of Nursing who confirmed the Surveyor's observations including a fruit fly flying in the room. The Surveyor returned to Resident #3's room on 3/18/26 at 8:45 AM. At that time the Surveyor counted 15 fruit flies in the Resident's bathroom, 2 fruit flies on the wall where the food trays were observed on 3/17/26 and one fruit fly on the sink. The Surveyor observed large cobwebs around both Resident's closet doors, dresser drawers remained dirty, peanut butter jars still had peanut butter on the outside of the jars and not in a sealed container, open ended pipe noted next to the toilet [NAME] out from the wall that doesn't appear to be in use, dry wall around sink with large cracks, old drill holes in wall under television. The Resident was again asked if he/she would be agreeable to a scheduled cleaning time. The Resident stated yes. The Surveyor returned to Resident #3's room on 3/18/26 at 9:00 AM with the Director of Nursing who confirmed the Surveyor's observations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to follow consultant physician orders for residents. This was evident for 2 (Resident #2 and #7) of 7 residents reviewed during a complaint survey.The findings include:1.The facility staff failed to follow the Wound Doctor orders for Resident #2.Review of Resident #2's medical record on 3/19/26 revealed the Resident had returned from the hospital on 1/27/26 and was seen by the Wound Doctor on 1/28/26. On 1/28/26 the Wound Doctor assessed the Resident to have a non-pressure sacral wound, and ordered the Resident to have silver sulfadiazine and calcium alginate dressing daily.Further review of the medical record revealed the Wound Doctor assessed the Resident again on 2/3/26 and 2/10/26 and ordered the Resident to have silver sulfadiazine and calcium alginate daily.Review of Resident #2's January 2026 medication and treatment records revealed the Resident did not receive the sacral wound treatments of silver sulfadiazine and calcium alginate until 2/18/26, 21 days later.Interview with the Director of Nursing on 3/20/26 at 11:45 AM confirmed the facility staff failed to provide Resident #2's sacral wound treatments as ordered by the Wound Doctor from 1/28/26 until 2/18/26.2.The facility staff failed to follow the preop instructions for Resident #7.Review of Resident #7's medical record on 3/17/26 revealed the Resident was admitted to the facility on [DATE] from the hospital and was scheduled to have an outpatient vascular procedure on 12/12/25.Further review of Resident #7's medical record revealed on 12/10/25 the Vascular physician's office sent preop instructions to the facility for Resident #7's 12/12/25 outpatient procedure. The instructions included for the Resident to not have anything by mouth after midnight the night prior and to stop Eliquis 2 days prior to the procedure. Eliquis is a blood thinner medication. The instructions also included the Resident could take Aspirin, Metoprolol, Vimpat and Gabapentin the morning of surgery with a small sip of water.Further review of Resident #7's medical record revealed the Resident was given food and fluids after midnight on 12/12/25.Review of Resident #7's December 2025 Medication Administration Record revealed the facility staff failed to stop the Resident's Eliquis 2 days prior and did not administer the Resident's Aspirin, Metoprolol, Vimpat and Gabapentin on 12/12/25 the day of the scheduled procedure.Further review of Resident's medical record revealed the Resident's outpatient procedure was rescheduled for 12/23/25.Interview with the Director of Nursing on 3/17/26 at 12:45 PM confirmed the facility staff failed to follow Resident #7's preop instructions for 12/12/25.