STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215308	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Crest Village	8800 Walther Boulevard Parkville, MD 21234

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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. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of the clinical record and interviews, facility staff failed to fully inform the Power of Attorney (POA) of a resident before conducting a diagnostic procedure. This finding was evident for one (Resident #16) out of six residents reviewed for injury of unknown origin during this complaint survey.The findings include:On 10/08/25 at 8:03 AM, the surveyor reviewed self-reported incident #312142, which was reported on 12/22/24 regarding Resident #16's possible disarticulation (fracture or dislocation) of the left knee. The report showed that a facility nurse noted the significant changes on 12/22/24, and Resident #16 subsequently received an X-ray.Further review of Resident #16's medical records and the facility's incident report on 10/08/25 at 8:30 AM revealed that the resident's spouse was the Power of Attorney (POA) and that the resident had received hospice care since October 2024.On 10/08/25 at 11:23 AM, the surveyor requested and reviewed documentation from hospice. The review revealed that Resident #16 was seen by hospice nurse (Staff #17) on 12/02/24, who noted: Left leg appears possibly disarticulated (fracture or dislocation). Discussed with [spouse] who indicated they did not wish to send patient to the hospital. X-ray deferred. NP and doctor notified.Further review of Resident #16's electronic medical records showed that Licensed Practical Nurse (LPN #19) wrote a clinical note on 12/22/24: Resident's leg has had a significant change and resident has visible signs of pain when the leg is moved. On-call ordered ice packs to the area, STAT (immediately) X-ray of the left knee/leg, and an evaluation of the area by the hospice nurse. However, there was no additional documentation to support that facility staff discussed treatment wishes with Resident #16's POA prior to ordering the X-ray, as an X-ray had been deferred on 12/02/24 with the hospice nurse. During an interview with the Assistant Director of Nursing (ADON) on 10/08/25 at 1:00 PM, she stated that facility staff were supposed to inform the on-call provider about residents' healthcare status (such as hospice status or agreement/disagreement with therapy) when receiving a new order. When asked about Resident #16's case, the ADON said she expected nurses to inform the provider that the POA had previously refused the X-ray.On 10/08/25 at 1:39 PM, the Nursing Home Administrator (NHA) provided copies of notes written by the attending Nurse Practitioner (Staff #16) on 12/23/24. The note had two paragraphs under the Abnormal Knee X-ray/Treatment section. The first paragraph stated: .Prior to the initiation of treatment for the left knee (differential diagnosis of cellulitis), X-ray was offered to the POA, but the POA declined. He/she also communicated 'no X-RAY, keep comfortable' to the [name of the company] hospice nurse. The left knee swelling, erythema, and warmth had improved; however, these knee features recurred, hence, an X-ray was ordered. The second paragraph indicated: Discussion with POA - he/she is not opposed to X-rays, only opposed to surgical treatment.During an interview with Staff #16 on 10/09/25 at 1:50 PM, the surveyor reviewed the progress notes with her and asked for an explanation of the conflicting nature of the two paragraphs. Staff #16 confirmed that the first paragraph detailed the POA's earlier decision. After the X-ray was taken per the on-call provider's order on 12/22/24, Staff #16 discussed the issue with the POA and updated the note. She verified that there was no documentation to support that facility staff had discussed Resident #16's (or the POA's) wishes regarding the X-ray prior to it being taken.During an interview with the NHA on 10/10/25 at approximately 12:15 PM, the surveyor shared the above concern, which the NHA validated.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and interview with staff, it was determined that the facility staff failed to protect the privacy of residents' medical information. This was found to be evident in 1 out of 3 nursing units observed during a complaint survey.The findings include:On [DATE] at 8:10 AM the surveyor observed a cart with a laptop, two pieces of paper, a plastic pitcher of water, 3 small containers (applesauce, vanilla pudding and chocolate pudding), and a pill crusher. The laptop screen was open with patient information visible in the hallway in front of room NG S335. Furthermore, the top paper on the cart had medical information of 11 residents visible that included their MOLST status (Medical Orders for Life-Sustaining Treatment: a medical document that contains a patient's wishes for life-sustaining medical treatments, like CPR and artificial ventilation), their diet, medications, and other important info (as observed on the paper). During the next 7 minutes, the surveyor stood by the cart and heard the nurse speaking to the resident and telling him/her that his/her spouse was going to come and pick up his/her clothes and wash them like s/he always does. They continued to converse as the surveyor stood outside of the room. On [DATE] at 8:17 AM the surveyor observed the Assistant Director of Nursing (ADON) and asked if she could come down to the cart. In an interview with the ADON, when asked if residents' medical information should be out in and visible for anyone to observe, she stated, No. The surveyor showed the ADON the open laptop and paper with resident information. On [DATE] at 8:18 AM Licensed Practical Nurse (LPN #8) exited the resident's room and walked upon the surveyor and ADON who were standing at her cart. In an interview with LPN #8 when asked if resident information should be out and visible she stated, No, it should always be covered up, but I went in the room because I did not like the way the resident was sitting. S/he was leaning. During the interview, the surveyor shared that they were standing out front of the room for 7 minutes and that someone walked by while the information was out. The surveyor shared this was a concern and the ADON and LPN #8 acknowledged understanding. On [DATE] at 9:12 AM the surveyor shared the above concern with the Nursing Home Administrator (NHA). The NHA stated the resident was about to fall and that is why the nurse went in there. The surveyor stated that they heard the nurse and resident calmly conversing about day to day tasks. Additionally, the surveyor stood outside the room near the cart for 7-8 minutes and observed someone walking by with the information out. The NHA stated he understood the concern.

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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 medical records review and staff interview, it was determined the facility staff failed to revise interdisciplinary care plans to reflect accurate interventions for residents. This was evident for one (Resident #21) of the six residents reviewed for injuries of unknown origin during this complaint survey.The findings included:On 10/06/25, at 2:07 PM, the surveyor reviewed facility's self-reported incident (312135) concerning Resident #21, who reported bruises on both arms on 11/04/24. The facility staff investigated this as an unknown origin of injury and concluded that the bruises resulted from Resident #21 propelling their wheelchair, during which their arms hit and rubbed against the wheelchair and the wheelchair brake extenders. In an interview with the Rehab Director (Staff #4) on 10/07/25, at 11:13 AM, he verified that Resident #21's initial evaluation, dated 5/22/24, stated that the resident required assist but was able to self-propel wheelchair. Furthermore, after the incident reported on 11/04/24, a therapist assessed Resident #21 and verified that self-propelling a wheelchair with an extended brake would be beneficial for the resident. During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 10/07/25 at 11:37 AM, the NHA confirmed that the facility's investigation concluded that Resident #21's bruises resulted from the extensions of the wheelchair brake. Additionally, the surveyor asked about interventions provided to prevent similar incidents. The NHA said that the rehab team evaluated the resident and documented their findings. The surveyor requested any documentation to support how the facility staff revised the plan of care for this resident. On 10/07/25, at 1:03 PM, the DON and NHA stated that the interventions for Resident #21 were documented in the progress notes; however, they were not updated on the care plan. The surveyor shared a concern that Resident #21's risk of bruises due to extended wheelchair brakes was not updated in the resident care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint and of the medical record, interviews with facility staff, and observation, it was determined the facility failed to provide assistive devices to residents that would allow the residents the ability to achieve the greatest independence with performing Activities of Daily Living (ADL). This was evident for 1 (#312111 regarding Resident #8) of 5 complaints reviewed during the complaint survey. The findings include:Activities of Daily Living (ADLs) are the basic, essential self-care tasks people need to perform to maintain their health, safety, and well-being, such as bathing, dressing, eating, and toileting.The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's health status, functional abilities, and needs. It is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident.A plate guard is an assistive device that clips onto a plate's edge to create a barrier, preventing food from being pushed off during eating. This helps people with limited dexterity, tremors, weak grip, or low vision to eat independently and mess-free by providing a wall to scoop food onto utensils. Plate guards are ideal for children and the elderly, as well as individuals with conditions like Parkinson's disease, stroke, or other neurological motor disorders. Built-up utensils are adaptive eating tools with enlarged, often foam or plastic-coated handles designed to make eating easier for people with arthritis, hand tremors, weak grip, or limited dexterity. These thick handles provide a more comfortable and secure grip, requiring less hand strength and putting less stress on finger joints, which helps users maintain independence and control during meals. Review of complaint 312111 on 10/7/25 at 10:01 AM revealed the complainant noted that Resident #8 had Parkinson's disease and difficulty feeding him/herself. Further review noted that the resident had built up utensils, but they were frequently dirty or missing.Review of the medical record on 10/7/25 at 8:17 AM revealed Resident #8 was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, Parkinson's with dyskinesia, dementia, dysphagia, and other chronic pain.On 10/7/25 at 10:17 AM review of the medical record revealed a MDS dated [DATE]. The review revealed Resident #8 was coded for Eating as 5. Set up or clean up assistance. Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. On 10/8/25 at 8:29 AM in an interview with Geriatric Nursing Assistant (GNA #10), when asked where to look to determine if a resident needed feeding assistance or had any other feeding needs, she stated on the long sheet in the nurse's station, in their chart, or on the Dining Detail. On 10/8/25 at 9:00 AM a copy of the Dining Details that hangs on the wall between the kitchen and dining room was provided by the Assistant Director of Nursing (ADON). Review of the Dining Details revealed that Resident #8's Equipment was documented as Built up utensils-keep in resident room and Plate Guard. A document titled, Dining Details Report- Supporting Nutritional Care provided by the Nursing Home Administrator (NHA) was reviewed on 10/9/25 at 8:10 AM. The review revealed, The Dining Details Report (DDR) is a document that is printed by dining leadership from myUnity (the facility's electronic medical record). Because this report comes directly from the electronic medical record, it contains the most current diet orders, dining preferences, allergies, and all the other details necessary to provide accurate and quality nutritional care for a resident. On 10/8/25 at 9:32 AM review of Resident #8's care plan revealed, I require the following nutritional approaches: .built up utensils. Further review revealed, I need the following devices to be as independent as possible eating: Built up utensils.On 10/8/25 at 12:34 PM Resident #8 was observed eating lunch in bed. The surveyor observed a sandwich, a drink, and sliced peaches in a white bowl with a fork; however, it was not a built up fork. On 10/8/25 at 12:40 PM the surveyor requested a dual observation of the concerns and interview with the ADON. The surveyor stood outside the room as the ADON entered the resident's room and greeted Resident #8. Upon exiting the room and when asked if the ADON observed a plate guard, she stated no. When asked if she observed built up utensils, she stated no. When asked why the resident did not have the built up utensils, she proceeded to reenter the resident's room and open the top drawer of his dresser. Then, she pulled out the plate guard and built up utensils wrapped in a napkin. Upon exiting the room and when asked why they were not being used, she stated s/he did not need utensils for a sandwich. The surveyor stated that s/he had a fork with his/her peaches; however, it was not a built up fork. The surveyor shared this along with not having the plate guard applied was a concern and she stated, I agree.On 10/8/25 at 1:50 PM the surveyor shared the concerns with the NHA who stated that he understood

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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 review of a complaint and of the medical record, interviews with facility staff, and observation, it was determined the facility failed to provide supplements as documented in a resident's care plan and Dining Detail. This was evident for 1 (#312111 regarding Resident #8) of 5 complaints reviewed during the complaint survey. The findings include:A document titled, Dining Details Report- Supporting Nutritional Care provided by the Nursing Home Administrator (NHA) was reviewed on 10/9/25 at 8:10 AM. The review revealed, The Dining Details Report (DDR) is a document that is printed by dining leadership from myUnity (the facility's electronic medical record). Because this report comes directly from the electronic medical record, it contains the most current diet orders, dining preferences, allergies, and all the other details necessary to provide accurate and quality nutritional care for a resident. Review of complaint 312111 on 10/7/25 at 10:01 AM revealed the complainant noted that Resident #8 did not receive ice cream with lunch, did not receive milkshake at 2 p.m., did not receive super spuds with lunch, did not receive a drink with lunch. Furthermore, the complaint noted that medical and nursing staff recommended hospice because s/he was losing weight; however, the ice cream, shakes and super spuds were interventions that the facility put in place but as noted above, did not hold to. Review of the medical record on 10/7/25 at 8:17 AM revealed Resident #8 was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, Parkinson's with dyskinesia, dementia, dysphagia, and other chronic pain.On 10/8/25 at 8:29 AM in an interview with Geriatric Nursing Assistant (GNA #10) when asked where do you look to determine if a resident needs feeding assistance or has any other feeding needs, she stated on the long sheet in the nurse's station, in their chart, or on the Dining Detail. On 10/8/25 at 9:00 AM a copy of the Dining Details that hangs on the wall between the kitchen and dining room was provided by the ADON. Review of the Dining Details revealed that Resident #8's Supplements should include L/D (lunch and dinner): vanilla ice cream and mashed potatoes with gravy. On 10/8/25 at 9:32 AM review of Resident #8's care plan revealed, Care Plan Approaches: Super spuds with lunch and dinner and ice cream with lunch and dinner. Further review revealed, a care plan update on 9/9/24 that the resident is offered in house shake at 2pm and super spuds with lunch and dinner. Additionally, on 9/13/24 the care plan was updated to ice cream with all meals and 2 in house shakes. Also, on 11/8/24 the care plan was updated, Resident did not want ice cream with breakfast just with lunch and dinner. In addition, on 12/4/24 it was noted Continue to offer in house shake at 2pm, ice cream and super spuds with lunch and dinner. Finally, on 3/12/25 it was noted, no changes to the nutrition plan of care and to continue the plan of care.On 10/8/25 at 12:34 PM Resident #8 was observed eating lunch in bed. The surveyor observed a sandwich, a drink, and sliced peaches in a white bowl; however, the observation did not include visualization of super spuds with gravy or vanilla ice cream. On 10/8/25 at 12:40 PM the surveyor requested a dual observation of the concerns and interview with the Assistant Director of Nursing (ADON). The surveyor stood outside the room as the ADON entered the resident's room and greeted Resident #8. Upon exiting the room and when asked if the ADON observed mashed potatoes (super spuds) with gravy, she stated no. When asked if she observed vanilla ice cream, she stated no. The surveyor shared this was a concern and she stated, I agree.

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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. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on investigation of complaints, medical records review, and staff interviews, it was determined that the facility failed to coordinate care for a resident receiving hospice services. This was evident that one (Resident #16) of 22 residents reviewed for their care during this complaint survey.The findings include:On 10/08/25, at 8:03 AM, the surveyor reviewed Self-Reported Incident #312142, which stated that on 12/22/24, Resident #16 was noted having a swollen left knee, and an X-ray was ordered for follow-up.Further review of the facility's investigation report showed that the Nursing Home Administrator (NHA) submitted the follow-up incident report on 12/26/24, with a summary of the incident: On November 27, 2024, the resident was noted with swelling to the left knee. It was red, warm to the touch, and the NP diagnosed the resident with cellulitis. The resident was started on an antibiotic and ibuprofen for infection, pain, and inflammation. On December 2, 2024, the resident's knee had further swelling and pain. A Hospice nurse assessed the resident and noted that the left knee appears possibly disarticulated (fracture vs. dislocation unknown). [Spouse] was notified and did not want to send the resident out to the hospital. This assessment/note was never discussed with the nursing staff of the facility. On 12/22/24, the nurse caring for the resident noted a possible dislocation, not knowing about the hospice nurse's previous note/assessment. A Self-report was initiated for an injury of unknown origin.On 10/08/25, at 9:43 AM, the surveyor reviewed Resident #16's medical records. In a review of the progress notes, it revealed that the resident was evaluated by a NP (Nurse Practitioner) on November 29, 2024, for a left knee that was swollen and painful to the touch, and the resident was started on an antibiotic for cellulitis. On 12/01/24, a facility nurse wrote the progress notes which indicated that the hospice nurse came to check on the resident and said the hospice doctor recommended discontinuing labs which were scheduled for 12/02/24. The hospice nurse updated that the resident's family agreed to discontinue the labs.The progress note dated December 22, 2024, by a nurse stated: The resident was noted with left knee swelling, redness, and the lower leg appeared to be misaligned with the knee. The resident did not seem to be in pain at rest, but when attempting to move the leg, he/she grimaced. The resident's leg had a significant change, and the resident has visible signs of pain when the leg is moved. The On-Call Provider ordered ice packs to the area, a STAT (immediately) X-ray of the left knee/leg, and an evaluation of the area by the hospice nurse.The surveyor requested the closed medical records for Resident #16 and reviewed them on 10/08/25, at 11:23 AM. The review revealed that the hospice nurse documented on the hospice visit communication on 12/02/24 as .the leg appears possibly disarticulated (fracture vs dislocation?). Discussed with [spouse] who indicated that they did not wish to send the patient to the hospital. So, X-ray was deferred. NP and doctor notified.In an interview with Registered Nurse (Staff #7) on 10/08/25, at 8:50 AM, she stated that the facility nursing staff communicated with the hospice team via phone for updates. When the surveyor asked whether they used documentation for the communication, Staff #7 replied: Usually, no. Phone call communication is the most common. In response to the surveyor's question about the hospice team's own note, Staff #7 stated: If the hospice nurse or aide needs to communicate, they will contact the providers (doctor or NP) directly.Additional interview with a nurse (Staff #11) on 10/08/25, at 8:56 AM, she confirmed that the facility staff mainly communicated with hospice staff verbally. She also said that hospice staff had their own documentation in a paper chart, but there was no formal communication conducted between facility staff and hospice staff.On 10/08/25, at 11:38 AM, the surveyor interviewed a hospice nurse (Staff #17) via phone call. She recalled Resident #16's swollen legs and explained that Staff #17 discussed the resident's condition with the facility NP and the resident's POA- Power Of Attorney. She confirmed that she documented all details in the visit communication notes.During an interview with the Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA) on 10/08/25, at 11:56 AM, they stated that the facility's nurses should communicate with hospice nurses through care plan meetings and hospice nurses' notes, which facility staff were to review. The surveyor reviewed Resident #16's medical records including hospice visit communication notes and progress notes with the ADON and NHA. They confirmed that there was no documentation to support the facility's nursing staff acknowledged discussion between hospice nurses and Resident #16's POA.

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility reported incidents, review of employee records, and interview with facility staff, it was determined that the facility failed to have documentation that a Care Associate (CA) was given abuse training after returning from suspension related to an allegation of abuse. This was evident for 1 (CA #18) of 2 Care Associates records reviewed during this complaint survey.The findings include:On 10/9/25 at 10:05 AM a review of a Facility Reported Investigation (FRI) noted that Resident # 2 complained that on 6/11/25 evening shift, a Care Associate (CA) pushed and pulled him around and unplugged his television. The resident denied pain at time of assessment and the resident's wife stated that resident appeared more confused, however the resident was able to provide a description of the CA #18.An interview was conducted with CA #18 on 6/12/2025 who stated that he/she had received report from the nurse to be very careful with the resident's Left arm. Resident was sitting in a chair and was assisted with changing his/her clothes and transferred to bed. CA #18 further stated that the television was on, and the resident was talking about the weather on the television. CA#18 denied turning off the television or unplugging the television and resident did not have any complaints about his/her care.As part of the investigation, the facility interviewed the staff that worked with Resident #2 on the evening and night shifts of 6/11/25 and day shift of 6/12/25. All staff denied that the television was unplugged and that the resident had been having bouts of confusion. Five residents on the same assignment as Resident #2 denied feeling mistreated and stated that they feel safe in the facility.A review of the actions taken by the facility on 10/09/2025 at 12:34 PM revealed that the facility notified the resident's wife, Baltimore County Police Department (BCPD), the Ombudsman, and Adult protective Services. An Xray was ordered on 6/12/25 of resident's left shoulder and arm, which was negative for a fracture or dislocation and showed moderate degenerative joint disease. CA #18 was suspended during the investigation. The conclusion of the investigation was that the allegation of abuse was not verified based on resident's interview, staff interviews, and the resident's history of dementia, confusion, and memory impairment.Review of the CA#18 personnel record on 10/9/2025 at 12:42 PM revealed that no training of abuse was conducted following the suspension date of 6/12/2025 and upon returning to work.On 10/9/25 at 12:50 PM in an interview with the Nursing Home Administrator (NHA), he stated that abuse training is done at least annually and in the case of an allegation of abuse, training is done before returning to work through a system called Workday. This is Human Resources (HR) system where there is a learning portion on abuse. When surveyor asked how do you know when training is completed, the NHA stated that he would communicate with HR to verify who had completed the training.On 10/09/2025 at 1:10 PM, the NHA was made aware that it was a concern that CA#18 had not completed abuse training after returning to work from suspension. The NHA verified and agreed that abuse training should have been done.