

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Patapsco Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9109 Liberty Road Randallstown, MD 21133	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews it was determined that the dietary staff failed to wear hairnets or beard nets while in the kitchen. This deficient practice was discovered during two observations of four staff during the complaint survey. The findings include: On 07/08/26 at 8:14 am while in the kitchen the surveyor observed Dietary Aide #3 on the tray line without a hairnet covering. The surveyor observed Dietary Aide #4 and Dietary Aide #6 in the kitchen without a hairnet or beard covering. During an interview with Dietary Manager #8 the surveyor asked what measures were in place to prevent hair from getting into the residents' food. Dietary Manager #8 verbalized the staff are required to wear hair nets or a hat to cover their hair. The cook is to ensure the policy is being reinforced if they are not present. The male staff that have beards, they will reinforce the need to wear a beard net. During an interview with Dietary Aide #3 the surveyor asked what measures are in place to prevent hair from getting into the food. Dietary Aide #3 verbalized not being sure and they just wear a hair net while serving food and while in the kitchen. The surveyor asked why they were not wearing a hairnet before the cook instructed them to put the hairnet on. Dietary Aide #3 verbalized they didn't realize they were not wearing a hair net. During an interview with Dietary Aide #4 the surveyor asked why they were not wearing a hair net. Dietary Aide #4 verbalized they were rushing and forgot to put on a hair net. On 07/10/26 at 10:52 am the surveyor observed [NAME] #19 in the kitchen without a beard covering.		

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and staff interview; it was determined that the facility failed to protect a resident (resident #13) from physical abuse from a facility staff member. This was evident for 1 of 15 residents reviewed during a complaint survey. The findings include: Facility Reported Incident #3090504 reviewed on 7/15/26 at 9:40am revealed an incident that occurred on 7/11/26 at approximately 8:00pm. The report revealed LPN #35 was alleged to have hit the Resident #13 with the resident's reacher aid. The report stated LPN #35 was suspended on 7/11/26 and his/her employment was terminated on 7/16/26. Review of the Resident #13's medical records on 7/15/26 at 11:05am revealed the resident had no issues of pain or other discomfort after the 7/11/26 incident. Resident #13 was evaluated by the facility's mental health provider and the resident denied any trauma because of the alleged abuse incident. There was no changes to medication or other treatments. Interview of Resident #13 on 7/16/25 at 9:00am confirmed the alleged abuse incident on 7/11/26. The resident denied hitting LPN #35 his/her reacher aid. The resident stated that he/she was upset that LPN #35 wasn't giving the resident the requested eye drops and he/she was using the reacher aid to get something on the floor. The resident stated LPN #35 took the reacher aid from the resident and hit him/her with it while yelling at him/her. Interview with LPN #35 on 7/16/26 at 2:18pm regarding the alleged abuse incident on 7/11/26 revealed LPN #35 denied that he/she verbally and physically abused the resident. LPN #35 stated that he/she attempted to explain to Resident #13 that there weren't any eye drops available for the resident to use. LPN #35 then stated that the resident became upset and shouted obscenities about LPN #35 and his/her family. LPN #35 then stated that the resident used his/her reacher aid to try to hit him/her causing their glasses to be broken. LPN #35 denied raising their voice at the resident but admitted that he/she she took the reacher aid from the resident and accidentally hit the resident on the arm with the reacher aid. Interview with the Director of Nursing (DON) on 7/20/26 at 10:30am revealed LPN #35's employment was terminated on 7/16/26. The DON confirmed that LPN #35's behavior was an inappropriate response Resident #13's alleged behavior.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interview it was determined that the facility staff failed to implement a person-centered care plan when a resident refused medications and when a resident refused personal care. This deficient practice was evidenced in 2 (#1 & #9) of 3 resident records reviewed for care plans during the complaint survey. The findings include: 1a. On 07/09/26 at 3:38 pm the surveyor spoke with Resident #1 and the resident verbalized they don't like the staff to touch them sometimes when personal care is needed. Assistant Director of Nursing (ADON) #2 was present during the interview. A review of Resident #1's electronic medical record (EMR) revealed the resident was refusing personal care including showers. 1b. On 07/13/26 at 3:01 pm a review of the Resident #9's EMR revealed there were several days that the resident refused to take their medications. A review of the resident's care plans revealed the resident did not have a care plan for refusing to take their prescribed medications. On 07/14/26 at 12:58 pm during an interview with ADON #2 the surveyor asked if a resident was consistently refusing medication or personal care that's necessary should the nursing staff initiate a care plan? ADON #2 verbalized a care plan should be initiated and Resident #1's refusal of ADL care and showers should have been care planned as well as Resident #9's refusing their medication should have been care planned. Care plans was an area the nursing leadership team was working to improve.		

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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 record review and interview, the facility failed to update a resident's (resident #15) care plan after two altercations with other residents. This was evident in 1 of 15 residents reviewed during a complaint survey. The findings include: Facility Reported Incident 3046303 reviewed on 7/14/26 at 9:35am revealed Resident #15 struck Resident #4 in the face on 6/11/26 at approximately 4:15pm. Both residents were located on the memory care unit at the time of the incident. The face strike by Resident #15 caused Resident #4 to have a swollen lip. The incident report stated that Resident #15 was removed from the memory care unit and relocated to another room. Review of Resident #4's medical record on 7/14/26 at 10:30am revealed the resident had a Brief Interview for Mental Status (BIMS) assessment score of 0, which revealed the resident had been assessed as having severe memory issues. Review of Resident #15's medical record on 7/14/26 at 10:45am revealed the resident had a BIMS = 0. Resident #15 was also being treated for anxiety and visual hallucinations. Resident #15 was moved on 6/11/25 to a new room outside of the memory care unit to a room on the 2nd floor. The resident had another abuse incident in July 4, 2026 when he/she was observed hitting Resident #14 in the face. Resident #15 was eventually moved to a private room on the 1st floor. Further review of Resident #15's medical record on 7/14/26 at 12:00pm revealed that the resident's only wandering assessment was in April 2026. There was no evidence of the resident receiving a new wandering assessment after being moved from the memory unit on 6/11/26 to a 2nd floor room outside of the memory unit or when the resident was moved to the 1st floor in July 2026. Review of the facility reported incident on 7/14/26 at 1:30p revealed witness statements from nursing staff that revealed that prior to the 6/11/26 incident, Resident #15 was agitated and wandering the memory unit. The resident was standing at the nursing station and hit Resident #4. Nursing staff separated the residents. The resident continued to try to strike other residents in the memory care unit and nursing staff stopped the resident from striking the other residents. Change in condition form dated 6/11/26 revealed Resident #15 was observed wandering around the unit prior to the incident. The surveyor attempted to interview Resident #4 about the 6/11/26 incident. The surveyor asked the resident about the 6/11/26 incident and the resident was unable to remember the incident. The resident was observed as being pleasant and did not appear to be in pain. The surveyor attempted to interview Resident #15 about the 6/11/26 incident. The surveyor asked the resident about the 6/11/26 incident and the resident was unable to remember the incident. The resident was observed with no issues with behavior. Interview with GNA #34 on 7/16/26 at 11:30am confirmed that the Resident#15 was agitated and hit Resident #4 in the face. The surveyor asked GNA #34 if Resident #15 wandered the unit normally prior to the 6/11/26. GNA #34 confirmed that Resident #15 normally wandered on the memory unit and become agitated frequently. The surveyor asked GNA #34 about the 7/4/26 incident when Resident #15 hit Resident #14. GNA #34 confirmed that Resident #15 hit Resident #14 and when Resident #15 was re-located outside of the memory building and was observed as being agitated. The surveyor asked GNA #34 if the resident had any changes to supervise the resident after being moved from the memory care unit. GNA #34 stated there were no changes in the GNA tasks regarding supervision of the Resident #15 for behavioral issues. Interview with the Assistant Director of Nursing (ADON) on 7/16/26 at 9:20am revealed that the DON interviewed both Resident #4 and Resident #15 after the 6/11/26 incident. The ADON confirmed Resident #15 had two incidents of hitting residents before he/she was moved to a private room on the 1st floor. The surveyor pointed out the change in condition on 6/11/26 which stated that the resident was (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wandering when he/she was on the memory unit but there was no evidence of a updated elopement assessment when he/she was moved after the 6/11/26 incident or the 7/4/26 incident. The ADON confirmed the facility failed to update the elopement assessment after any of the abuse incidents. The surveyor also asked if any changes to the resident's behavior care plan after the 6/11/26 or the 7/4/26 incident. The ADON stated no changes was made to the resident's behavior care plan after the incidents.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interviews it was determined that the facility staff failed to adhere to professional nursing standards by not documenting on the medication administration record (MAR) when narcotics were administered but removed from the narcotic inventory and write legibly on the narcotic inventory sheet. This deficient practice was evidenced in 1(#9) of 2 resident narcotic records reviewed during the complaint survey. The findings include: The Maryland Nurse Practice Act guide and governs nursing practice in the state of Maryland. Registered Nurses, Licensed Practical Nurses, and certificate holders are expected to practice within the established regulations defined by the Nurse Practice Act. According to 10.27.10.02 B (3) (c) (i) (ii) The LPN contributes to the nursing assessment by communicating the assessment on records that reflect data recorded in a manner which is complete, timely, accurate and consistent with general standards of nursing practice. On 07/14/26 at 2:30 pm a record review revealed Resident #9 was ordered Hydromorphone 2 mg give 1 tablet by mouth (PO) every 4 hours as needed (PRN) for moderate pain 5-8 & give 2 tablets PO every 4 hours PRN for severe pain 9-10. A review of narcotic card revealed Licensed Practical Nurse (LPN) #28 signed the narcotic card as removing Hydromorphone 2 mg (1 tablet) on 07/02/26 at 8:10 pm and documented on the medication administration record (MAR) the resident had a pain score of 10. On 07/03/26 at 8:20 LPN #28 failed to document if the narcotic was removed during am or pm. On 07/03/26 at 3:45 am LPN #28 documented they removed Hydromorphone 2 mg (2 tablets) the narcotic was signed off as administered on the MAR. On 07/06/26 LPN #28 failed to document the time and how many Hydromorphone tablets were removed from the narcotic stock. On 07/07/26 LPN #28 documented the removed Hydromorphone 2 mg (2 tablets) and Hydromorphone 2 mg (1 tablet) the times the medication was removed was not legible. There was one entry on the MAR dated 07/07/26 that LPN #28 administered the medication. On 07/08/26 at 6:30 am LPN #28 removed Hydromorphone 2 mg (2 tablets) from the narcotic stock. LPN #28 documented on the MAR the resident had a pain score of 8. LPN #28 administered Hydromorphone 2 mg (2 tablets) when Resident #9 should have received 1 tablet according to the physician's order. On 07/14/26 at 3:05 pm while on the unit Liberty the surveyor reviewed the narcotic book on Medication Cart #1 and Medication Cart #2. The narcotic books did not include a Master Signature Sheet. The surveyor asked LPN #17, LPN #20, and LPN #30 where the Master Signature Sheet were located, but they were able to locate the sheets. The surveyor asked if they typically use a Master Signature Sheet and they all replied, yes. At 3:12 pm the surveyor asked DON #18 if the facility use a Master Signature Sheet for the narcotic books. DON #18 verbalized it was not mandatory for them. The surveyor made DON #18 aware Resident #9's Hydromorphone narcotic card had multiple signatures that were illegible. The surveyor provided DON #18 a copy of the narcotic card and they identified each illegible signature. At 3:44 pm the surveyor went to the unit [NAME] and observed a Master Signature Sheet in the narcotic book on Medication Cart #1. Medication Cart #2 did not have Master Signature Sheet. During an interview with Director of Nursing (DON) #18 on 07/15/26 at 10:48 am the surveyor asked who was responsible for oversight of the narcotics including audits. DON #18 verbalized the nursing leadership team including themselves after responsible for oversight of the narcotics. DON #18 was responsible for completing the narcotic audits. Typically, the narcotic audits were completed weekly on Thursday, that is when the unused discontinued narcotics are destroyed. Any of the nurses can complete the task. The surveyor reported LPN #28 had multiple illegible signatures on the narcotic card, multiple entries that did not coincide with the narcotic stock and MAR, and administered a narcotic not according to the physician's order. DON #18 verbalized LPN #28 received a disciplinary action with a final warning for their medication (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	errors. On 07/15/26 at 4:46 pm during an interview with LPN #28 the surveyor discussed they removed Hydromorphone 2mg for Resident #9 several times but did not sign the MAR that the medication was given. Also, the medication was not consistently given as ordered and their signature was illegible. LPN #28 verbalized they pulled the narcotic and were supposed to document on the MAR the medication was administered. LPN #28 verbalized they did not document accurately.		

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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 medical record review and interviews it was determined that the facility staff failed to administer medications according to the scheduled times. This deficient practice was evidenced in 1 (#12) of 1 medication administration audit record reviewed during the complaint survey. The findings include: On 07/16/26 a review of Resident #12's medication administration audit record revealed on 07/02/26 during the 7:00 am - 3:00 pm and 3:00 pm - 11:00 pm shifts the resident's medications were administered outside of the 1 hour before or 1 hour after the designated time frame when the medication was scheduled for administration. On 07/02/26 at 9:00 am the resident was scheduled to receive Nifedipine 90 mg for high blood pressure (HTN), Valporic Acid 250 mg for seizures, Carvedilol 25 mg for HTN, Losartan Potassium 100 mg for HTN, and Pantoprazole 40 mg for acid reflux. Licensed Practical Nurse (LPN) #31 documented on the medication administration record (MAR) that the medications were administered at 12:05 pm. The resident was scheduled to receive Gabapentin 100 mg at 4:30 pm for neuropathy pain; the medication was documented as administered at 9:18 pm by LPN #13. Carvedilol 25 mg for HTN & Valporic Acid 25 mg for seizures were scheduled for administration at 5:00 pm. The medications were documented as given at 9:18 pm by LPN #13. Oxycodone 5 mg for pain was scheduled for administration at 6:00 pm and LPN #13 documented that the medication was administered at 9:18 pm. On 07/20/26 at 11:21 am during an interview with Director of Nursing #18 the surveyor asked who was responsible for ensuring the residents receive their medications during the scheduled times. DON #18 verbalized the floor nurses and anyone who has clinical capabilities can see on the dashboard and Resident #12 requested to receive their medications after dialysis. They need to update the residents' care plan to reflect their request to receive their meds after dialysis. However, the date in question was Thursday 07/02/26; the resident received dialysis on Monday, Wednesday, and Friday.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review and staff interview, the facility staff failed to provide supervision to prevent a mentally unstable resident (Resident #15) from physically abusing a vulnerable residents (Resident # 4 and Resident #14). This was evident for 1 out of 15 residents reviewed during a complaint survey. The findings include: Facility Reported Incident 3046303 reviewed on 7/14/26 at 9:35am revealed Resident #15 struck Resident #4 in the face on 6/11/26 at approximately 4:15pm. Both residents were located on the memory care unit at the time of the incident. The face strike by Resident #15 caused Resident #4 to have a swollen lip. The incident report stated that Resident #15 was removed from the memory care unit and relocated to another room. Review of Resident # 4's medical record on 7/14/26 at 10:30am revealed the resident has a Brief Interview for Mental Status (BIMS) assessment score of 0, which revealed the resident had been assessed as having severe memory issues. Review of Resident #15's medical record on 7/14/26 at 10:45am revealed the resident had a BIMS assessment score of 0. Resident #15 was also being treated for anxiety and visual hallucinations. Resident #15 was moved on 6/11/25 to a new room outside of the memory care unit to a room on the 2nd floor. The resident had another abuse incident on July 4, 2026 when he/she was observed hitting another Resident #14 in the face. Resident #15 was eventually moved to a private room on the 1st floor. Further review of Resident #15's medical record on 7/14/26 at 12:00pm revealed that the resident's only wandering assessment was in April 2026. There was no evidence of the resident receiving a new wandering assessment after being moved from the memory unit on 6/11/26 to a 2nd floor room outside of the memory unit or when the resident was moved to the 1st floor in July 4, 2026. Review of the facility reported incident on 7/14/26 at 1:30p revealed witness statements from nursing staff that revealed that prior to the 6/11/26 incident, Resident #15 was agitated and wandering the unit. The resident was standing at the nursing station and hit Resident #4. Nursing staff separated the residents. Resident #15 continued to try to strike other residents in the memory care unit and nursing staff stopped Resident #15 from striking the other residents. A change in condition form dated 6/11/26 revealed Resident #15 was observed wandering around the unit prior to the incident. The surveyor attempted to interview Resident #15 about the 6/11/26 incident. The surveyor asked the resident about the 6/11/26 incident and the resident was unable to remember the incident. The resident was observed no issues with behavior. Interview with GNA #34 on 7/16/26 at 11:30am confirmed that the Resident #15 was agitated and hit Resident #4 in the face. The surveyor asked GNA #34 if Resident #15 wandered the unit normally prior to the 6/11/26. GNA #34 confirmed that Resident #15 normally wandered on the memory unit and became agitated frequently. The surveyor asked GNA #34 about the 7/4/26 incident when Resident #15 hit Resident #14. GNA #34 confirmed that Resident #15 hit Resident #14 and when Resident #15 was located outside of the memory care unit. Resident #15 was observed as being agitated. The surveyor asked GNA #34 if Resident #15 had any changes in how to supervise the resident after being moved from the memory care unit. GNA #34 stated there were no changes in the GNA tasks regarding supervision of Resident #15 for behavioral issues. Interview with the Assistant Director of Nursing (ADON) on 7/16/26 at 9:20am revealed that the DON interviewed both residents after the 6/11/26 incident. The ADON confirmed that Resident #15 had two incidents of hitting residents before he/she was moved to a private room on the 1st floor. The ADON confirmed the facility failed to update the elopement assessment after any of the abuse incidents. The surveyor also asked if any changes to Resident #15's behavior plan after the 6/11/26 or the 7/4/26 incidents and the ADON stated no changes were made to the resident's behavior plan after the incidents.		

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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. Based on record review and interviews it was determined that the pharmacy failed to provide accurate medication labels of the narcotic that was distributed to the facility. This deficient practice was evidenced in 1 (#12) of 2 resident medication regimens reviewed during the complaint survey. The findings include: On 07/20/26 at 11:30 am during an interview with Director of Nursing (DON) #18 the surveyor asked why the nurses were signing two separate Oxycodone 5 mg tablet narcotic administration cards for Resident #12. The surveyor asked if the nursing staff were administering Oxycodone 10 mg to the resident. Resident #12's narcotic order read Oxycodone 5 mg give one and one-half tablet (7.5 mg) by mouth (PO) every 6 hours for pain. DON #18 verbalized the pharmacy distributes Oxycodone 5 mg tablets and Oxycodone 5mg in half tablets which is Oxycodone 2.5 mg. The pharmacy label did not indicate that half tablets were provided. The surveyor verbalized Resident #12 Oxycodone 5 mg narcotic cards does not indicate Oxycodone 2.5 mg tablets were distributed. During a telephone interview with pharmacy Operations Manager #33 who verbalized the Oxycodone prescription for Resident #12 was Oxycodone 7.5 mg. The pharmacy did not have Oxycodone 2.5 mg tablets. They distribute Oxycodone 5 mg 1/2 tablet which equates to Oxycodone 2.5 mg. The surveyor verbalized the label on the Oxycodone 5 mg narcotic card did not indicate a half tablet was distributed. The pharmacy label appeared confusing and inaccurate. Operations Manager #33 verbalized they can check with their compliance team to determine whether the label needs to be adjusted. The Oxycodone 5 mg tablets were cut into half tablets at the pharmacy and packaged individually on the narcotic card. On 07/20/26 at 4:05 pm the surveyor received an email from Pharmacy Manager #29 which read they dispensed Oxycodone 5mg 60 whole tablets and Oxycodone 5 mg 30 half tablets for 60 doses for Resident #12. They do not stock Oxycodone 2.5mg tablets as the medication was not made in that strength.		

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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. Based on medical record review and interviews it was determined that the facility staff failed to ensure they used the five rights before administering a narcotic and administered the wrong medication. This deficient practice was evidenced in 1 (#12) of 3 medication administration records for 1 resident (Resident #12) reviewed during the complaint survey. The findings include: On 07/14/26 at 3:53 pm the surveyor reviewed Resident #12's narcotic sign out sheet for Hydromorphone 2 mg. The pharmacy sticker with the order on the narcotic card read Hydromorphone 2 mg give one tablet by mouth every four hours as needed for pain. Continued review revealed that on 07/02/26 at 9:30 pm Licensed Practical Nurse (LPN) #13 signed off they administered 5 tablets to the resident and 7 tablets remained. However, on 07/15/26 at 9:48 am a review of Resident #12's electronic health record revealed the order Hydromorphone 2 mg 1 tablet every 4 hours by mouth was discontinued on 07/02/26 at 6:56 am. The nursing staff confirmed the medication was discontinued on 07/02/26 at 12:23 pm. LPN #13 had removed Hydromorphone 2 mg (5 tablets) from Resident #12's narcotics at 9:30 pm on 7/2/2026, after the order was discontinued. On 7/14/26, the surveyor observed Unit Manager #25 and LPN #13 taking narcotics into an office to dispose of the medications. The surveyor asked Unit Manager #25 how many tablets were left on Resident #12's Hydromorphone 2 mg narcotic card. Unit Manager #25 verbalized there were 7 tablets left before they were disposed. At 4:15 pm, during an interview with LPN #13 the surveyor asked why they administered 5 tablets which equated to Hydromorphone 10 mg to Resident #12 when the resident supposed to receive Hydromorphone 2 mg which was one tablet. LPN #13 verbalized there was a separate order that he faxed to the pharmacy for Hydromorphone and the pharmacy could not get Hydromorphone 10 mg tablets. The surveyor asked where the order was. LPN #13 verbalized there was a separate order for the resident to receive Hydromorphone 10 mg when the resident came to the facility from the hospital and the order was in the electronic health record. A review of Resident #12's medication administration record (MAR) for July 2026 revealed LPN #13 did not sign the MAR that Hydromorphone was administered to the resident. The surveyor did not see an order for Resident #12 to receive Hydromorphone 10 mg as LPN #13 reported. During an interview with Director of Nursing (DON) #18 the surveyor asked who was responsible for oversight of the narcotics including audits. DON #18 verbalized the nursing leadership team including themselves were responsible for oversight of the narcotics. DON #18 was responsible for completing the narcotic audits. Typically, the narcotic audits were completed weekly on Thursday, that's when the unused discontinued narcotics are destroyed and any of the nurses can complete the task. The surveyor asked at what point are the unused or discontinued narcotics destroyed. DON #18 verbalized ideally it would be best to destroy them immediately but per their policy at least weekly. The surveyor provided DON #18 with their policy and asked to point out where the Controlled Substance Administration Policy stated the narcotics could be destroyed weekly. After reviewing the policy DON #18 confirmed the policy did not indicate when discontinued narcotics would be destroyed by the nursing staff. Resident #12's Hydromorphone was discontinued on 07/02/26 but the remaining 7 tablets were not destroyed until 07/14/26. At 10:55 am the surveyor made DON #18 and ADON #2 aware LPN #13 signed off Resident #12 narcotic card Hydromorphone 2 mg 5 tablets when the order called for 1 tablet as needed. DON #18 verbalized they spoke with LPN #13 who verbalized they were mistaken and signed off they gave Hydromorphone and thought they were giving Hydrocodone. DON #18 verbalized Resident #12 received Hydromorphone 10 mg instead of Hydrocodone 10 mg. DON #18 verbalized they had no knowledge of the incident until the surveyor brought it to their attention. At 3:05 pm during an interview with LPN #13 the surveyor reported there was not an order for Resident (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Patapsco Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9109 Liberty Road Randallstown, MD 21133	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#12 to receive Hydromorphone 10 mg. LPN #13 verbalized the order was for another resident and they made a medication error. There was another order for Hydrocodone 10 mg, and they thought that's what they were administering. LPN #13 revealed the resident was very agitated and they were thinking the Hydromorphone was Hydrocodone. Normally they would do the five rights of medication administration, but the resident came from the hospital and was in a lot of pain. Further review of Resident #12's medication administration record revealed LPN #13 signed off administering Hydrocodone Extended Release 12-hour 10 mg 1 capsule by mouth on 07/02/26 at 9:30 pm and Oxycodone 7.5 mg (1 1/2 tab) by mouth on 07/02/26 at 9:30 pm. The Oxycodone 5 mg narcotic cards verified the medication was taken from the narcotic stock. LPN #13 administered two separate Opioid narcotics to Resident #12 on 07/02/26 at 9:30 pm.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews it was determined that the facility staff failed to ensure the freezer located in the kitchen was properly sealed to prevent air from getting into the freezer and ice build-up inside of the freezer. This efficient practice was discovered during the complaint survey. The findings include: On 07/08/26 at 8:25 am while in the kitchen the surveyor observed the freezer door opened with ice throughout the freezer including boxes of food, the shelves, the floor, and the ceiling of the freezer. Under further inspection the surveyor observed the seal on the freezer's door was compromised. During an interview with Dietary Manager #8 reported a new freezer door was ordered and Maintenance Director #9 was handling the issue with the freezer door and the door was ordered but they haven't seen an invoice. When the door doesn't shut properly ice builds up in the freezer. During an interview with Maintenance Director #8 they reported the seal around the freezer door is bad and the door had been beaten up over the years. A new door had not been ordered although they requested a new freezer door be purchased. The contractor requested the freezer door be replaced. On 07/09/26 at 12:13 pm the surveyor received and reviewed two work order reports received from Maintenance Director #8. The report dated 04/02/26 indicated the walk-in freezer door was damaged and solutions were offered. Also, there was documentation that stated the door frame was damaged and would not properly accept a new door gasket. The surveyor could not verify if the repairs were completed. Another work order report dated 05/19/26 did not indicate the seal around the freezer was replaced. The surveyor did not receive verification that a new walk-in freezer door was ordered or was scheduled to be repaired.		