STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215085	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Park Healthcare	3330 Wilkens Avenue Baltimore, MD 21229

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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. 50573 Based on review of facility investigation and interview with facility staff, it was determined that the facility failed to ensure that a resident remained free of abuse. This was evident for 1 (MD00216920) of 46 Facility Reported Incidents (FRIs) reviewed during an annual survey. The findings include: On 05/13/25 at 9:37 AM, review of facility documentation provided by the facility for MD00216920 revealed that in the early morning of 4/21/25, Resident #23 alleged Geriatric Nursing Assistant (Staff #36) was providing care to them, and Resident #23 told Staff #36 to stop and leave the room. Staff #36 continued to provide care despite the resident's request to stop. On 05/13/25 at 9:39 AM, further review of MD00216920, revealed a written statement from Geriatric Nursing Assistant (Staff #37) stating she was present during the incident. Staff #37 indicated in their written statement that Resident #23 told Staff #36 to stop and get out, but that Staff #36 continued to provide care. Further review of the facility documentation for MD00216920 at the same time revealed that Resident #23's Brief Interview for Mental Status (BIMS) was 15. A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS assessment uses a points system that ranges from 0 to 15 points. Scores from 13-15 indicate intact cognition. On 05/14/25 at 07:39 AM, an interview with the Director of Nursing revealed that Staff #36 was put on the Do Not Rehire list because Resident #23 asked Staff #36 to stop providing care and she continued. The Director of Nursing further indicated that it was the expectation for staff to stop providing care if a resident indicated so.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 51786 Based on review of records and interviews, it was determined that the facility failed to implement its abuse policy. This was evident for 1 (Resident #61) of 5 residents reviewed for abuse allegations. The findings include: On 5/12/2025 at 10:56 AM, a review of the facility reported incident (MD00199361) was conducted. The review revealed an allegation of physical abuse towards Resident #61 on 11/9/2023 at 3:30 am. The alleged perpetrator was Staff #19, date of hire 8/22/23. On 5/12/2025 at 11:26 AM, an interview with Resident #61 was conducted. When asked about the incident, Resident #61 stated that s/he called the police that day and that the police officer had told him/her that Staff #19 was working on another unit. On 5/12/2025 at 1:26 PM, facility was asked to provide Staff #19's Timecard for 11/9/23. On 5/13/2025 at 10:37 AM, the requested timecard was received. Review of this document indicated that Staff #19 clocked in at 11:10 pm on 11/8/23 and clocked out at 7:08 am on 11/9/23. On 5/13/2025 at 10:47 AM, a brief interview with the Human Resource Director was conducted. S/he confirmed that Staff #19 continued to work his/her shift even after the allegations of abuse had been reported. On 5/13/2025 at 11:24 AM, a review of the facility's abuse policy was conducted. According to the facility's policy, after an abuse allegation towards the residents, the alleged perpetrator is to be removed from the facility and away from other residents immediately. On 5/13/2025 at 1:24 PM, facility administrator was made aware of concerns with the implementation of abuse policy.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50385 Based on record review and staff interviews, the facility failed to report (1.) unusual occurrences, (2.) allegations of abuse in the required timeframe and (3.) allegations of abuse to a law enforcement agency. This was evident for 3 (Resident #58, #59 and #90) out of 10 residents reviewed for facility reported incidents. The findings include: 1.) On 5/09/25 at 10:11 AM, a review of Facility Reported Incident #MD00216808 was conducted. The incident report states that on 4/13/25. Resident #58 was found lethargic and difficult to be aroused, was placed on 3 liters of Oxygen via nasal canula, and given 2 doses of Narcan. Resident #58 was then sent out to the ER. Resident #58 tested negative for all medications except Methadone which s/he was taking at the time. On 5/9/25 at 10:31 AM, a review of Resident #58's progress notes and the facilities investigation documentation was conducted. Based on progress notes the incident happened at 8:35 AM on 4/13/25. Upon further investigation the initial report was submitted to the OHCQ at 12:30 PM on 4/17/25. The final report was submitted on 4/22/25. On 5/9/25 at 10:47 AM, an interview was conducted with the Director of Nursing and the administrator. When asked if they were aware that the incident was not reported in a timely manner. They stated that they were not aware that they were supposed to report incidents not involving abuse within 24 hours of the incident. 2.) On 5/9/25 at 7:30 AM, Facility Reported Incident #MD00206541 was reviewed. In the incident Resident #59 alleged Resident #67 sexually assaulted them. The incident documentation showed the incident was reported to the Office of Health Care Quality at 1:26 pm on 5/30/24. The incident was documented to have happened at 2:30 pm on 5/29/24. On 5/13/25 at 9:39 AM, an interview with the Director of Nursing (DON). The DON confirmed the incident happened on 5/29/24 at 2:30 pm and was reported on 5/30/24 at 1:26 pm. This surveyor made the DON aware that all allegations of abuse must be reported to appropriate agencies within two hours. 50904 3.) On 05/13/2025 at 9:03 AM, this surveyor reviewed the intake MD#00217660 and found out that the facility had reported an allegation of abuse to the state agency. In the self-report sent to the state agency, Resident #90 had reported that a nurse pulled his/her mask, yelled at him/her and took a video of him/her without consent. On 05/13/2025 9:10 AM, this surveyor reviewed the facility reported investigation packet and discovered that Law enforcement agency was not notified of the alleged abuse incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2025 at 11:50 AM, in an interview with the Director of Nursing (DON), when she was asked who was notified whenever there was an abuse allegation, she stated that abuse allegations were reported to the State agency, the law enforcement agency, and the ombudsman. When asked whether the alleged abuse identified in intake #MD00217660 was reported to the law enforcement agency, she stated that she was not an employee at the facility at the time of the incident. She also informed the surveyor that if a police investigation number and related details were not found in the investigation packet, it meant the incident was not reported. The surveyor informed her that no police investigation number and related detail was included in the packet. She reviewed the investigation packets and confirmed that a police investigation number and related details were not included and added that the law enforcement agency was not notified.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 50385 Based on record review and staff interview, it was determined that the facility failed to maintain records of investigation documentation. This was evident for 2 (Resident #38 and #53) out of 10 residents reviewed for facility reported incidents. The findings include 1.) On 5/7/25 at 2:19 PM, Facility Reported Incident #MD00206207 was reviewed. It was reported that Resident #53 alleged that $70 was stolen from their possession. On 5/8/25 at 1:00 PM, the facilities investigation of Resident #53's money was reviewed. The investigation file contained only the initial and follow-up self-reports that were submitted to the Office of Health Care Quality. On 5/8/25 at 2:00 PM, an interview was conducted with the Director of Nursing (DON). When asked if the investigation file provided was the complete investigation for Resident #53's incident, the DON stated, Yes, that is all we have. When asked if they were able to provide any statements, interviews, in-services, or education from this investigation, the DON stated that what was in the file is all they had. The surveyor requested Resident #53's inventory lists. The facility was able provide the document. 50904 2.) On 05/09/2025 at 7:45 AM, a review of facility reported incident #MD00207676 was conducted. The incident report revealed that Resident #38 was found to be high, drowsy, and sleeping in the walkway. One of the aides reported that this behavior was unusual for this resident. He/She would normally return to his/her bedroom to sleep if needed. On 05/07/2025 at 10:00 AM, another surveyor requested for the facilities investigations for all facility reported incidents from Nursing Home Administrator (NHA). On 05/09/25 at 01:43 PM, this surveyor requested the facilities investigation relating to Resident #38 from the Director of Nursing (DON) and she stated that the NHA was still looking for it. On 05/09/25 at 02:02 PM, in an interview with the NHA, when she was asked for the investigation packet for the intake MD#00207676, she informed the surveyor that the investigation packet could not be found, and that the facility does not have it. On 05/09/2025 at 2:41 PM when the DON and the NHA were asked how long a document should be kept, the DON stated that for 5 years and when the concern about the missing investigations were discussed with them, they both acknowledged that the document should have been made available upon request and kept for 5 years.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on observation, interviews, and record reviews, it was determined that facility staff failed to 1) ensure the resident's nutritional status was accurately assessed, documented, and up to date in accordance with healthcare standard of care guidelines and 2) provide services that meet professional standards by not following written physician orders. This deficient practice was evident for 2 residents (#13 and #67) reviewed during the annual survey. Based on record reviews, observations, and interviews, it was determined that facility failed to provide services that meet professional standards by not following written physician orders. This was found to be evident for Resident #67 during the annual survey. The findings include: During the initial tour of residents on the 4th floor on 05/07/25 at 7:48 AM, the surveyor entered room [ROOM NUMBER] and observed Resident #13 sleeping in bed. The resident appeared malnourished with signs of cachexia (wasting syndrome). Review of the resident's electronic medical records (EMR) revealed the resident has a diagnosis of quadriplegic and is completely dependent on facility staff for all activities of daily living. On 05/07/25 at 10:48 AM, review of complaint intake MD00200515 revealed that the resident's family had concerns regarding the resident's care and nutritional status. During an interview with Resident #13's family on 05/08/25 at 4:28 PM, they stated the resident lost a lot of weight and mentioned how staff often fail to ensure the resident received meals. A review of the EMR on 05/08/25 at 1:06 PM, indicates that quarterly nutritional assessments were conducted by the Registered Dietitian (RD) # 18 on 7/5/24, 01/16/25, and 04/18/25. It is noted that the resident is meeting more than 75% of estimated calories and protein needs based on the last documented weight. Review of the resident's weight summary indicates that the last documented weight was on 02/29/24. The residents' orders include a regular double portion meal and a liquid protein supplement. A review of meal intake records for June 2024, July 2024, December 2024, and January 2025 shows that Resident #13 consumed on average 50% of meals provided for breakfast, lunch, and dinner. On 05/09/25 at 3:05 PM, during an interview, with RD #18, he explained that nutritional assessments are conducted at the time of admission, quarterly, annually, and when there are significant changes in the resident's condition. The surveyor asked why some assessment dates were missing for Resident #13. The RD #18 states that an assessed was conducted between July 2024 and January 2025, however, it was not documented resident's EMR. Instead, the assessment was documented in a Google Drive file on the RD's computer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor inquired about the RD #18's documentation indicating that the resident was meeting more than 75% of estimated calories and protein needs based on the last recorded weight, although the resident had not been reweighed. The RD #18 explained that the assessment was based on the resident being ordered a double portion meal. When asked if he possibly overestimate the resident's calorie and protein intake per meal, the dietitian was unable to confirm if overestimation had occurred. He further explained that the resident nutritional supplements were changed to ensure adequate protein intake and to address both malnutrition and wound healing. The surveyor noted that the resident's medical record did not include documentation to indicate why the supplement was changed. The Administrator was present during the interview with the registered dietitian. 51589 On 5/7/2025 at 10:37 AM, during the initial screening of Resident #67, left hand contractures were observed by the surveyor. No brace or splint was observed on the resident's left hand. Further review of the resident's medical records on 5/8/2025 at 12:00 PM revealed an order initiated on 10/2/2024 that stated the resident is to wear left palm grip for contracture management and only to be removed during daily hand hygiene. No additional information was able to be found in the resident's chart documenting use of palm grip, contradictions to usage, or resident refusal by the surveyor. Additional observations of Resident #67 on 5/8/2025 at 1:00 PM and on 5/9/2025 at 8:17 AM revealed that the resident was not wearing a palm grip in their left hand. On 5/9/2025 at 8:38 AM, Resident #67 was observed by surveyor and Licensed Practical Nurse (LPN) #15, LPN #15 confirmed resident was not receiving hand hygiene at the time and was not using a left palm grip. LPN #15 was also observed by the surveyor to not be able to find documentation of palm grip usage in resident's electronic health record. LPN #15 stated to the surveyor that they would contact the unit manager to make them aware. Resident #67 was observed to have palm grip in left hand by surveyor on 5/9/2025 at 9:23 AM. The Director of Nursing was made aware of surveyor concerns at 9:42 AM, no additional information was provided by facility staff regarding Resident #67 not using a palm grip during previous observations by surveyor.

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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. 50457 Based on interviews, observations and record reviews, it was determined that facility staff failed to ensure that wound care treatment was completed as ordered by the physician. This deficient practice was evident for 1 (#13) of 5 residents reviewed for physician orders during the annual survey. The findings include: During an interview with Resident #13 on 5/9/25 at 12:30 PM, the resident reports that wound dressing changes are scheduled for every Tuesday, Thursday, and Saturday, however, the dressing change for Thursday 5/8/25 was not done. An observation of Resident #13's left arm revealed that the last dressing change occurred on Tuesday 5/6/25 which is outside the ordered treatment schedule. On 05/09/25 at 1:30 PM, during a record review for Resident #13's treatment administration records (TAR) reveal an order to cleanse and dress wound located on the left forearm every evening shift every other day. Further review of the TAR reviewed that that last recorded wound dressing change was documented on 05/06/25. There was no documentation indicating why the change was not completed on 05/08/25. On 05/12/25 at 09:12 AM, during an interview with the Director of Nursing (DON), she states that staff are expected to document the status of all wound dressing changes including when a dressing change is not completed. The surveyor informed the DON of the undocumented wound care and reviewed the missing documentation in the medical records. The DON states that she will address documentation expectations with the staff.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on record reviews and staff interviews, it was determined that facility staff failed to ensure that geriatric nursing assistant (GNA) maintained an active certification. This deficient practice was evident in 1 out of 7 GNA employee files reviewed during the annual survey. The findings include: On [DATE] at 2:30 PM, during an interview with the Administrator, the surveyor requested the employment file for GNA #40. On [DATE] at 9:30 AM, during an interview with the Human Resource Director #10, the surveyor again requested for the employee file for GNA #40. During a review of the employee file, the surveyor identified that the GNA's certification had expired on [DATE]. On [DATE] at 2:30 PM, the surveyor informed the Administrator that GNA #40's certification expired. The Administrator stated that the employee was not working that day and would follow up with the HR Director #10 regarding the status of the GNA's license. On [DATE] at 7:53 AM, the Administrator confirmed that the GNA's certification is expired. On [DATE] at 7:58 AM, during an interview with HR Director #10, the surveyor inquired about the process for ensuring staff certifications and licenses remain current and active. The HR Director #10 states that at the time of hire, she notates certification and licenses on a spreadsheet on the computer and reviews the expiration dates monthly. When asked about GNA #40's expired certification, the HR Director #10 acknowledged that it was an oversight.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50457 Based on record reviews and interviews, it was determined that facility staff failed to ensure that annual performance reviews were conducted for all geriatric nursing assistant (GNA). This deficient practice was evident in 7 out of 7 GNA's annual performance reviewed during the annual survey. The findings include: On 05/08/25 at 10:42AM, the surveyor requested the complete GNA employee files for GNA's, 23, #24, #25, #26, #27, and #28. The surveyor informed the Human Resource (HR) Director #10 that each file should also include the employee's annual performance review. A review of the employee files on 05/09/25 at 7:58 AM for GNA's #23, #24, #25, #26, #27, and #28 revealed that the requested annual performance review were not included in the submitted files. On 05/09/25 at 2:30 PM, the surveyor informed the Administrator of the requested GNA employee files and the missing annual performance reviews. The Administrator stated that the HR Director #10 would locate the requested files. The surveyor requested an additional GNA employee file for GNA # 40. On 05/12/25 at 9:30 AM, during an interview with the HR Director #10, she explained that employee appraisal reviews are conducted annually. The surveyor made a second request for annual performance reviews for GNA's, #23, #24, #25, #26, #27, #28 and #40. The HR Director stated that she would locate the files. On 05/14/25 at 8:02 AM, during an interview, the Director of Nursing (DON) explained that she completes GNA annual performance reviews upon receiving a list of upcoming review due dates. She further stated that the HR Director #10 will verbally notify her if any reviews are incomplete by the deadline date. The DON notes that the GNA annual appraisal includes goals, areas of strength, areas of improvement, future goals and expectations. The surveyor informed both the Administrator and the DON that the GNA employees' files, including annual performance reviews, were requested on 05/08/25. As of 05/14/25, the requested files had not been provided. Both the Administrator and DON acknowledged that the surveyor would no longer request the files.

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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. 50385 Based on record review and staff interview, it was determined the facility staff documented inaccurate data in the resident's chart. This was evident in 1 out of 6 resident's reviewed in the recertification survey. The findings include: On 5/13/25 at 8:02 AM, a review of Complaints #MD00199200 and #MD00200378 was conducted. Both complaints alleged the facility provided a lack of Quality of Care leading to Resident #94's transfer to hospital requiring critical care. On 5/13/25 at 8:35 AM, a review of Resident #94's records was conducted. A progress note on 11/6/23 at 8:50 AM indicated the resident was going to be sent out to the ER at the family's request. A progress note on 11/6/23 at 9:36 PM indicated that the resident was out of the facility. Review of the resident's blood pressure indicated the resident's blood pressure on 11/6/2023 at 8:31 AM was documented as 85/63 mmHg. On 11/7/23 at 5:06 AM, the resident's blood pressure was documented as 129/75 mmHg. On 5/13/25 at 10:23 AM, an interview with the Director of Nursing (DON) was conducted. When asked about how Resident 94's blood pressure was documented after discharge date , The DON stated they did not know how or why that blood pressure was documented after the resident was discharged . When asked what the expectation was for documentation after discharge, the DON stated no documentation of vital signs should be done after resident has been discharged . 50573

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385 Based on observations and record review, it was determined the facility failed to maintain an effective pest control program. This had the potential to affect all residents. The findings include: On 5/12/25 at 6:25 AM, An observation was made in the facility lobby, hallway, and conference room. 1 large black and brown insect was observed in the conference room, 1 large black and brown insect was observed in the hallway of the 1st floor, 1 large black and brown insect was observed on the hallway of the 4th floor, and 1 large black and brown insect was observed in the Lobby. On 5/12/25 at 7:00 AM, the facilities pest control logs were reviewed. Based on log documentation, multiple roach sighting. 12/5/24- 12/11/24 and treated on 12/13/24. Multiple roach sightings were reported on 12/15/24 through 12/20/24 and treated on 12/27/24. A roach sighting was reported on 12/30/24 and treated on 1/10/25. On 5/12/25 07:20 AM, a review of Facility Reported Incident #MD00204936 from 4/23/24 was conducted. A report was made to the Office of Health Care Quality of a Bedbug sighting in the Lobby on 4/15/24. On 5/12/25 at 7:25 AM, the Director of Nursing was made aware of the insect sightings on 5/12/25. On 5/12/25 at 7:38 AM, a review of the facility's investigation of Bed bugs sighted in lobby on 4/15/24 was conducted. The facility's pest control company came to the facility on [DATE] to treat the facility for bed bugs. The pest control technician did not see any bed bugs at the time of report. The technician completed an initial treatment for bed bugs including products of Cimexa, Crossfire, and Temprid. Per the technician's report product was applied with sprayer to cracks and crevice of beds, bed frames, box springs, headboards, dressers, couches, chairs, molding & trim, carpet seaming, smoke detectors, electrical switches & sockets, curtain & shade brackets, & closet shelving. On 5/12/25 at 10:15 AM, an interview was conducted with the Maintenance Director (Staff #3). When asked if they were aware of a current insect problem, Staff #3 stated they were aware of waterbug sightings and stated that the pest control company had been treating the facility for them. Staff #3 stated that they were not aware of this being a current issue. This surveyor made Staff #3 aware of the sightings made on 5/12/25. On 5/14/25 at 11:16 AM, a review of Complaint #MD00201889 was conducted. The complaint stated there was evidence of mice in a resident's room on the 4th floor in December 2023. On 5/14/25 at 11:20 AM, a review of the pest control log of December 2023 was conducted. 24 mice sightings were documented in the month of December. In the pest control log, there was documented mice sightings throughout the 4th floor on 12/5/23.