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	05/15/2026

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that facility staff failed to accurately code the resident's status on the Minimum Data Set assessment. This deficient practice was identified for 2 (Resident #100 and #2) out of 6 residents reviewed for Minimum Data Set assessments.The MDS is a federally mandated, comprehensive, standardized clinical assessment tool of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care that they need. The findings include: (1) On [DATE] at 9:49 AM, during the review of complaint 2977960, it was noted in Resident #100's electronic health record that he/she was readmitted to the facility on [DATE] and transferred to the hospital via Emergency Medical Services (EMS) on [DATE]. On [DATE] at 11:31 AM, review of progress notes in Resident #100's electronic health record revealed that Resident #100 had an order for intravenous normal saline fluids on [DATE] due to dehydration and attempts to establish intravenous access were unsuccessful. The medical provider was notified and ordered transfer to the hospital. The spouse was notified, and 911 was called. Paramedics arrived and transferred the resident from the unit to the hospital. Documentation indicated he/she was stable at the time of transfer. On [DATE] at 1:31 PM, review of Resident #100's Emergency Department records summary indicated that he/she presented to the hospital on [DATE] at 4:20 PM with altered mental status, dehydration, and shortness of breath. The resident's medical history included peripheral vascular disease, coronary artery disease, chronic kidney disease, hypernatremia, dehydration, sacral pressure ulcers, open amputation wound, osteomyelitis, hypertension, and small bowel obstruction with colostomy. Upon arrival at the Emergency Department, Resident #100 was nonverbal, appeared delirious, and was not following commands. Prior to successful establishment of intravenous access, the resident experienced cardiopulmonary arrest. In accordance with his/her Medical Orders for Scope of Treatment indicating Do Not Resuscitate status, cardiopulmonary resuscitation was not initiated. Brief assisted ventilation was provided while cardiac arrest was confirmed, and the resident was pronounced deceased at 4:40 PM. On [DATE] at 1:07 PM, during an interview with the facility's Minimum Data Set Coordinator regarding the process for unplanned hospital discharges, the coordinator stated that such discharges were coded as Discharge Return Anticipated when the facility expected the resident to return. The coordinator stated that facility staff would follow up with the hospital to determine whether the resident had been admitted . When asked who was responsible for communicating the outcome of the (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up, the coordinator stated that the nursing team would provide updates during clinical meetings. When asked about coding requirements for a resident who dies within 24 hours after transfer from the facility, which was the case for Resident #100, the coordinator stated that she was not aware the resident had expired shortly after transfer to the hospital. The MDS coordinator further stated that she had not completed the original discharge coding and had recently begun employment at the facility. When asked what the correct coding should have been, the coordinator stated that the discharge should have been coded, or updated, as death in facility if the original coding was inaccurate. When asked whether the coding was incorrect, the coordinator acknowledged that it was. On [DATE] at 1:54 PM, during an interview with the Director of Nursing (DON), it was stated that palliative care had been recommended upon admission; however, the family declined those services. The Director of Nursing stated that shortly after admission, a family member informed the facility that they tested positive to COVID-19, adding that they had contact with the resident. The Director of Nursing further stated that the resident later developed respiratory symptoms, tested positive for COVID-19, and was placed on appropriate precautions. The DON added that Resident #100's condition continued to decline, and the resident was transferred to the hospital on [DATE] due to dehydration and unsuccessful attempts to establish intravenous access for rehydration. The Director of Nursing also stated that the facility was later informed by a family member that the resident died a few hours after transfer to the Emergency Department. On [DATE] at 7:44 AM, during an interview with Licensed Practical Nurse (LPN#19), the nurse stated that the resident appeared dehydrated on the day of transfer and that two attempts to establish intravenous access were unsuccessful. The nurse stated that the attending provider (Staff #19) was contacted and subsequently ordered transfer to the hospital for further evaluation and treatment. When asked if the resident was admitted into the hospital, he stated that he was uncertain whether the resident was admitted to the hospital because the facility was informed shortly after transfer that the resident had died at the emergency department of the hospital On [DATE] at 9:35 AM, the Minimum Data Set coding issue was discussed with the Director of Nursing, who acknowledged and confirmed that the coding was entered in error. (2) On [DATE] at 10:30 AM, a review of Resident #2's EMR (electronic medical record) revealed that Resident #2 was admitted on [DATE] with diagnoses including but not limited to schizoaffective disorder and major depressive disorder. Further review revealed that the Facility Physician (Staff#20) prescribed Invega Sustenna (an antipsychotic medication) for Resident #2 to receive intramuscularly every 28 days. Resident #2's quarterly MDS dated [DATE] failed to document in Section N Medications that Resident #2 was prescribed and being administered an antipsychotic medication. On [DATE] at 1:20 PM, during an interview with the MDS coordinator (Staff #5) confirmed that Resident #2's MDS from [DATE] did not accurately document Resident #2's medications by failing to code for antipsychotics.

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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 record review and interview, it was determined that the facility failed to provide care in accordance with the standards of practice, when Resident #28 was documented to not have a stool for 8 days (from 05/03/2026 to 05/10/2026) and no PRN bowel protocol medications were ordered or administered nor were abdominal assessments documented in the progress notes as per facility policy. This was evident for 1 (Resident #28) out of 18 residents reviewed for quality of care. The findings include: Facility's Bowel Management Protocol Policy and Procedure: Purpose- To establish a standardized bowel management protocol to prevent constipation, fecal impaction, avoidable hospital transfers, discomfort, and bowel-related complications. Policy- Residents shall receive individualized bowel management based on assessment findings, diagnosis, medications, risk factors, providers orders, and clinical condition. Nursing staff shall proactively monitor bowel function and intervene timely.High risk residents; includes but is not limited to: opioid use, reduced mobility. poor oral intake. 4. Intervention Escalation-. NO BM (bowel movement) for 48 hours: implement ordered first-line intervention, examples- stool softener, senna, miralax, PRN (as needed) ordered bowel medication, NO BM for 72 hours: Licensed nurse must: reassess resident, notify provider, implement additional intervention per provider order. On 05/11/2026 at 10:45 AM, during the screening process Resident #28 stated, I have not had a BM in 6 days. On 05/12/2026 at 9:41 AM, a review of Resident #28's EMR (electronic medical record) revealed that Resident #28 was admitted on [DATE] with diagnoses including but not limited to, C5-C7 (cervical spine) complete quadriplegia, S/P (status post) gastrostomy (feeding tube directly to the stomach) and polyneuropathy. A review of Resident #28's EMR also revealed that there was no evidence of Resident #28 having a BM from 05/03/2026 to 05/10/2026 (a total of 8 days) in the bowel movement task section of the EMR. Further review of Resident #28's EMR revealed no evidence of any documentation in the progress notes dated 05/03/2026 to 05/10/2026 by nurses or GNAs of Resident #28 having a bowel movement nor was there any documentation referencing constipation, an abdominal assessment or notification of a provider regarding the lack of bowel movement. A review of Resident #28's orders lacked evidence of any PRN medication orders to alleviate constipation during this time frame. It should be noted that during these 8 days, Resident #28 was administered 17 doses of PRN oxycodone (an opioid pain medication) for pain. On 05/13/2026 at 9:37 AM, during an interview the Director of Nursing stated that once a resident is noted to not have stool for 3 days, the unit manager and nurse confirm that the resident has not had a stool in 3 days. Then they initiate the bowel protocol. Bowel protocol consists of PRN medications such as a fleets enema, stool softener and miralax. On 05/13/2026 at 10:28 AM, during an interview with Licensed Practical Nurse (Staff #4) (ADON/ unit manager) stated, When residents are without stool for 3 days, the nurse call the physician for a fleets enema order. We don't have standing orders for fleets. [Resident #28] does have a standing order for senna (stimulant laxative) each night and miralax (osmotic laxative) each morning. I will look to see if there is a note from a nurse about how they were treating his lack of stool from 5/3 to 5/10. During this interview, LPN4 confirmed that the GNAs should document in the bowel movement task section when a resident had a stool. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/13/2026 at 11:04 AM, a follow up interview with Staff #4 stated, I was not able to find any notes documenting the staff reaching out to the providers for PRN bowel protocol medications or documenting an abdominal assessment for the 8 days that Resident #28 did not have a stool. I put a call out to the provider for an order for a fleets enema.