| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215085 | A. Building<br>B. Wing | 06/24/2026 |

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

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| F 0563<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.<br><br>Based on a review of administrative records, medical records, and interviews with family members and facility staff, it was determined that the facility failed to ensure residents' rights were protected by restricting visitation in residents' rooms. This deficient practice was identified for 1 (#5) of 5 residents reviewed during a complaint investigation conducted at the facility.Findings include:Complaint Intake #3015004 was reviewed on June 24, 2026, for multiple allegations. One allegation stated that all visitation with the resident was required to occur in a large common room on the first floor and not in the resident room.During the survey, an observation was made of a notice posted on the glass at the front desk that stated:Attention Residents, Visitors, and Staff: Effective immediately, in our continued effort to ensure the safety, privacy, and well-being of all residents, visitors will no longer be permitted in individual resident rooms. We kindly ask that all visits take place in designated common areas, such as the game room or front lobby, where everyone can enjoy a comfortable and welcoming environment.An interview was conducted with the complainant, a family member of the resident, on June 24, 2026, at approximately 3:00 p.m. The family member stated that she had not been permitted to visit the resident in the resident's room because the facility had discontinued room visitation. She further stated that the resident preferred receiving visits in the comfort and privacy of his/her room and that the facility no longer allowed this preference.During observation rounds conducted on June 24, 2026, at approximately 11:00 a.m., Resident #5 was observed lying in bed. No clinical, safety, or other factors were identified that would prevent the resident from receiving visitors in his/her room.An interview was conducted with the Administrator and Director of Nursing (DON) on June 24, 2026, at approximately 3:25 p.m. When asked whether family members were permitted to visit residents in their rooms, the Administrator stated that room visitation was prohibited due to concerns that visitors could bring drugs into the facility. The Administrator further stated that this concern existed prior to her tenure as Administrator. However, the Administrator was unable to provide documentation demonstrating that drug activity was a current issue within the facility. The Administrator stated that exceptions were made for residents who were bedbound or had health-related concerns, but that other residents were not permitted to receive visitors in their rooms.The Administrator was informed that restricting room visitation in this manner constituted a violation of residents' rights. |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on medical record review and interviews it was determined the facility failed to ensure that a comprehensive care plan was revised, and to ensure a scheduled care plan meeting was conducted. These deficient practices were identified for 2 (#1, #5) of 5 residents reviewed during a complaint investigation conducted at the facility.Findings include:<br><br>A care plan is intended to identify and address each resident's unique needs, goals, and preferences. It serves as a guide to coordinate, assess, and evaluate the effectiveness of care and services provided.<br><br>1.<br><br>A review of Resident #1's medical record on 06/24/2026 at 10:30 AM revealed a progress note dated 05/23/2026 at 04:32 PM that stated While eating lunch, resident was observed coughing and having difficulty swallowing food. The resident stated that he/she was having difficulty swallowing.<br><br>A review of Resident #1's medical record on 06/24/2026 at 10:45 am revealed a physician's order dated 05/23/2026 at 03:15 PM for a modified mechanical soft, chopped meat diet. Further review revealed a physician order dated 05/23/2026 at 03:15 PM for a Speech-Language Pathologist swallowing study to be done.<br><br>A review of Resident #1's care plan on 06/24/2026 at 11:00 AM revealed a nutritional focus area with corresponding goals and interventions initiated on 12/05/2024. Further review demonstrated that the facility failed to revise the care plan to include Resident #1's change in clinical status regarding swallowing difficulties and the subsequent modification to the diet.<br><br>During an interview on 06/24/2026 at 4:30 pm the Administrator Staff #1 and the Director of Nursing Staff #2 were made aware of the concerns for failure to update a care plan to address a resident's change in condition status.<br><br>2.<br><br>Resident #5 was admitted to the facility with diagnoses that included, but were not limited to, dementia and Parkinson's disease.<br><br>A review was conducted on 6/24/26 at 11:30AM of the resident'selectronic medical record and documents provided to the survey team revealed invitations for care plan meetings scheduled on February 10, 2026, at 11:30 a.m. and May 28, 2026, at 11:30 a.m. Documentation also included progress notes dated May 26, 2026, and May 28, 2026. There were no meeting notes for the scheduled meeting for February 10, 2026.<br><br>An interview was conducted with the complainant, a family member of Resident #5, on June 24, 2026, at approximately 3:00 p.m. The family member stated that she contacted the facility on multiple occasions regarding concerns about the resident's care and did not receive a response. She further stated that a care plan meeting was supposed to occur earlier in the year; however, she was not contacted regarding the meeting until May 2026, despite multiple attempts to communicate with facility staff.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Social Services Director (SSD) on June 24, 2026, at approximately 3:30 p.m. When asked whether the care plan meeting scheduled for February 10, 2026, had occurred, the SSD stated that the meeting was not conducted due to human error. The SSD acknowledged that the scheduled meeting was missed and stated that the next care plan meeting was held on May 26, 2026.<br><br>The DON was informed of the concern regarding Resident #1's care plan and acknowledged the finding. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure that enteral nutrition was administered in accordance with physician orders and accepted standards of nursing practice for 1 (#4) of 3 residents reviewed for enteral feedings. This deficient practice resulted in the resident receiving significantly less enteral nutrition than ordered due to incomplete physician orders and the facility's failure to ensure the feeding was administered as prescribed.The findings include:During a complaint investigation (Complaint #3039711) conducted on 06/24/2026 at approximately 9:00 a.m., observation of Resident #4 revealed the enteral feeding formula bottle hanging empty at the bedside without a label identifying the date, time, or infusion rate. The resident stated that the tube feeding was supposed to continue until 1:00 p.m.At that time, the Unit Manager was requested to activate the enteral feeding pump so the surveyor could verify the volume administered. Review of the pump history revealed the resident had received 655 cc (cubic centimeter) of the 1,700-cc ordered.Review of the medical record at 9:15am revealed a physician order dated 06/16/2026 for Jevity 1.5 administered via intermittent pump at 85 cc/hour during the evening. The order did not specify the feeding start or stop times.During an interview on 06/24/2026 at approximately 9:30 a.m., Licensed Practical Nurse (LPN) #13 stated the feeding pump was already off when she began her shift. When asked how she determined when the feeding should start or stop, the nurse stated she would need to review the physician orders.During an interview on 06/24/2026 at approximately 9:40 a.m., the Director of Nursing (DON) accompanied the surveyor to Resident #4's room and observed that the feeding remained off and without a label identifying the date, time, or infusion rate. The DON stated she would speak with the assigned nurse to determine why the feeding was not infusing and was not labeled correctly.During a follow-up interview on 06/24/2026 at approximately 11:00 a.m., the DON acknowledged that the physician's enteral feeding order was incomplete because it did not include specific feeding start and stop times. She also stated the enteral feeding was not labeled correctly.During an interview on 06/24/2026 at approximately 4:00 p.m., the Registered Dietitian stated the resident is now receiving the correct amount of enteral nutrition and indicated that the feeding order should have been corrected upon the resident's return from the hospital on [DATE]. He stated the order was not correctly transcribed as written in his assessment.Following surveyor intervention, the attending physician was notified, and the enteral feeding orders were revised to clearly identify the appropriate feeding schedule. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on record review and interviews, the facility failed to implement physician orders, and to provide the necessary care and services to assess, monitor, and timely respond to changes in a resident's condition. This was evident in 2 (#1, #4) of 5 residents reviewed for quality of care; treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. The findings include:<br><br>1.<br><br>A review of Resident #1's medical record on 06/24/2026 at 10:30 AM revealed a progress note dated 05/23/2026 at 04:32 PM, that stated while eating lunch the resident was observed coughing and having difficulty swallowing food. The resident stated that he/she was having difficulty swallowing. The Nurse Practitioner Staff #10 was made aware and gave orders for the resident to have a Speech-Language Pathologist swallowing test and a diet change to mechanical soft/chopped meat.<br><br>A review of Resident #1's medical record on 06/24/2026 at 10:45 am revealed a physician's order dated 05/23/2026 at 03:15 PM for a Speech-Language Pathologist swallowing study to be done.<br><br>During an interview on 06/24/2026 at 02:40 PM Nursing Home Administrator (NHA) Staff #1 stated that there is one person who does the swallowing tests and that the test had not been done for Resident #1. The surveyor asked the NHA Staff #1 if the swallowing test had been scheduled with the speech therapist and NHA Staff #1 stated that he/she would verify if it was scheduled.<br><br>During an interview on 06/24/2026 at 02:55 PM Dietician Staff #8 was asked by the surveyor if Resident #1's swallowing test had been scheduled. Dietician Staff #8 stated that he/she was never made aware of an order for a swallowing test and that nursing staff would have set this up.<br><br>During an interview on 06/24/2026 at 04:25 PM with the Nursing Home Administrator Staff #1, the Director of Nursing (DON) Staff #2, the DON verified that the swallowing test for Resident #1 had not been scheduled and had not been done.<br><br>2.<br><br>Resident #4 had diagnoses that included chronic urinary tract infection, Cystitis and an indwelling Foley catheter.<br><br>Cystitis is a medical term for inflammation of the bladder. It is mostly caused by a bacterial infection (a lower urinary tract infection).<br><br>Medical record review conducted on 06/24/2026 at approximately 11:30 a.m. revealed a nursing progress note dated 06/05/2026 at 4:04 p.m. documenting that the resident complained of burning with urination. The note indicated that an order was obtained to change the Foley catheter and obtain a urine specimen. The Foley catheter was changed, the urine specimen was collected, and the laboratory was contacted for a STAT specimen pickup.<br><br>A nursing progress note dated 06/06/2026 at 6:56 a.m. documented that the urinalysis obtained on 06/05/2026 revealed abnormal findings including protein, blood, and leukocyte esterase. Documentation indicated the on-call Nurse Practitioner (Staff #12) was notified of the abnormal (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | results and instructed that the findings be reviewed with the attending physician. The note further documented that the resident showed no signs of infection during that shift. Although the Foley catheter had been changed, the medical record contained no evidence that antimicrobial therapy or additional clinical interventions were initiated following the abnormal urinalysis findings.<br><br>Review of an MDS Focus Note dated 06/08/2026 at 9:06 a.m. documented, for the look-back period of 06/02/2026 through 06/08/2026, No reported signs and symptoms of infection at this time from use of Foley catheter indwelling. This documentation was inconsistent with the nursing note dated 06/05/2026, which documented the residents' complaint of burning with urination.<br><br>Review of the laboratory report revealed that on 06/08/2026 at approximately 10:00 a.m., the facility was notified that the urine culture specimen appeared contaminated and that a repeat urine culture was recommended. The medical record revealed that a repeat urine culture was not ordered until 06/09/2026 at 11:56 a.m.<br><br>A Social Services progress note dated 06/09/2026 at 11:22 a.m. documented that during the resident's scheduled interdisciplinary care plan meeting, the resident was unable to remain awake or actively participate. The resident's sister expressed concern that the excessive sleepiness was not consistent with the resident's baseline condition and requested that the meeting be postponed pending a medical evaluation. The interdisciplinary team agreed that further medical assessment was warranted.<br><br>Medical record review revealed that on 06/09/2026 at 12:16 p.m., approximately four days after the resident's initial complaint of burning with urination, orders were obtained for Ceftriaxone 1 gram intramuscularly STAT, Bactrim DS twice daily for seven days for cystitis, and STAT laboratory testing including a complete blood count (CBC), basic metabolic panel (BMP), and C-reactive protein (CRP).<br><br>A nursing progress note dated 06/09/2026 at 7:22 p.m. documented that the resident was lethargic, difficult to arouse, and did not respond to verbal commands or stimuli. Assessment findings included a blood pressure of 67/49 mmHg, pulse of 83, respirations of 14, oxygen saturation of 94%, and temperature of 99.8 degrees F. The physician was notified, and the resident was transferred to the Hospital via 911 for evaluation of suspected sepsis. The resident's emergency contact was notified of the transfer.<br><br>During an interview conducted on 06/24/2026 at approximately 2:00 p.m., the Director of Nursing stated the facility delayed initiating treatment while awaiting urine culture and sensitivity results. When asked why additional interventions were not initiated after the resident complained of painful urination, the abnormal urinalysis findings were received, and the laboratory recommended repeating the contaminated culture, the Director of Nursing stated that the Nurse Practitioner who had initially been notified of the abnormal findings was no longer employed by the facility.<br><br>The facility failed to ensure that Resident #4 received timely assessment, monitoring, diagnostic follow-up, and treatment after exhibiting symptoms of a possible urinary tract infection and after abnormal laboratory findings were identified. This failure resulted in a delay in clinical intervention and culminated in the resident experiencing significant clinical deterioration requiring transfer to the acute care hospital for suspected sepsis.<br><br>The resident admitting diagnosis to the hospital was Cystitis. |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>Based on medical record review and interviews with facility staff, it was determined that the facility failed to ensure a physician's medically necessary visit addressed a resident's change in clinical status regarding swallowing difficulties and subsequent follow-up orders. This was evident for 1 (#1) out of 1 resident reviewed during the complaint survey. Findings include:A review of Resident #1's medical record on 06/24/2026 at 10:30 AM revealed a progress note dated 05/23/2026 at 04:32 PM, that stated while eating lunch the resident was observed coughing and having difficulty swallowing food. The resident stated that he/she was having difficulty swallowing. The Nurse Practitioner Staff #10 was made aware and gave orders for Resident #1 to have a Speech-Language Pathologist swallowing test, a diet change to mechanical soft/chopped meat and a chest x-ray. A review of Resident #1's medical record on 06/24/2026 at 01:00 PM revealed a progress note completed by Physician Staff #9 dated 05/26/2026 at 12:30 PM that stated History and Physical Patient seen for pre-op H&P for Bilateral Retrograde Pyelogram scheduled for 5/28/26. There was no entry that addressed Resident #1's 05/23/2026 change in condition related to difficulty swallowing, diet changes, chest x-ray or swallowing test order. During an interview on 06/24/2026 at 4:30 pm the Administrator Staff #1 and the Director of Nursing Staff #2 were made aware of the concerns for lack of documentation by physician services regarding Resident #1's swallowing risks and follow up for the swallowing evaluation. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observations and interviews with the facility staff it was determined the facility failed to ensure that a resident call bell was within reach. This was found to be evident for 1 (#5) of 6 residents observed during a complaint survey conducted at the facility.Findings include: During observation rounds on 6/24/26 at approximately 10:50AM Resident #5's call light was observed on the floor behind the head of the bed.A dual observation was obtained at that time with the nurse (LPN # 7) and she picked the call light up from the floor and placed it near the resident. The nurse stated that when the resident was provided with morning care the aide should have made sure the resident's call light was within reach.The observation findings were discussed at the exit conference on 6/24/26 with the Administration team. |