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	06/30/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a clinical record, and staff interview, it was determined that the facility failed to notify Resident #2's representative in a timely manner after a fall in the shower room. This was evident for 1 (Resident #2) out of 3 residents reviewed during a complaint survey. The findings include: Review of complaint 3055512 on 06/29/26 revealed an allegation that Resident #2 had 2 falls (on 06/12/26 and 06/13/26) after being admitted and that Resident #2's responsible party was not immediately notified of the falls. Review of Resident #2's clinical record on 06/29/26 revealed that Resident #2 was admitted to the facility on [DATE] after suffering an ischemic stroke with thrombolysis and thrombectomy, aphasia, dysphagia, and being unsteady of their feet and in need of assistance with care. Resident #2 had a BIMS score of 11/15 as documented on 06/18/26. Further review of Resident #2 clinical record revealed that Resident #2 was found on their knees on 06/12/26 at approximately 8 pm. A review of the 06/12/26 post fall SBAR communication form signed on 06/12/26 by LPN#1 revealed that LPN#1 did not notify Resident #2's representative after this fall because no one was listed. LPN#1 also documented Resident #2 was not identified with any injuries and did not hit their head during the fall. Further review of Resident #2's clinical record revealed nursing documentation od a Near Miss - Fall on 06/13 26 at 12:15 pm. The Near Miss - Fall indicated that a geriatric nursing assistant (GNA) informed the nurse that Resident #2 was lowered to the floor which was a near fall. The nursing staff documented that Resident #2 stated that he almost fell, but due to both GNA's being in the shower, he was lowered to the floor. A review of the facility Fall Prevention and Management Policy on 06/30/26 revealed the facility policy had an effective date of 05/15/2025. The Fall Prevention and Management Policy defined a FALL as: an unintentional change in position, coming to rest on the ground, or a lower level. A NEAR MISS is defined as a slip, trip, or loss of balance that does not result in a fall to the ground. In an interview with LPN#2 on 06/30/26 at 2:48 pm, LPN#2 stated that a GNA informer her that Resident #2 had a near miss fall while in the shower and that Resident #2 was lowered to the floor. LPN#2 stated that she was aware of Resident #2 falling in the shower. LPN#2 stated that she did not notify Resident #2's responsible party of the fall because no one had informed her that Resident #2 fell in the shower. LPN#2 stated that later in the day on 06/13/26 at 4:30 pm, the oncoming nurse informed her that Resident #2 had a fall in the shower around 12 noon on 06/13/26 and that Resident #2's family was inquiring why there was not a phone call to the responsible party at the time of the fall in the shower.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a clinical records, and resident and staff interviews, it was determined that the facility staff failed to provide treatment to maintain dental health for Resident #1. This is evident for 1 out of 3 residents reviewed during a complaint survey. The findings include: Review of complaint 3055728 on 06/29/26 at 11 am listed an allegation that Resident #1 was not given access to care. Review of Resident #1 clinical record on 06/29/26 revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that included but not limited to a stroke with left hemiparesis, s/p craniotomy with swelling around the right ear, chronic pain, migraines, insomnia, trigeminal neuralgia and bruxism. Resident #1 is dependent upon the nursing staff for several aspects of their care. Further review of Resident #1's June 2026 physician's orders revealed the following dental orders:1) 12/17/25 - Have Resident #1 be evaluated and treated by the facility Dentist as needed.2) 03/18/26 - Have Resident #1 be evaluated and treated by the facility Dentist services.3) 03/28/26 - 7 am, Have Resident #1 be evaluated and treated by the facility Dentist for the diagnosis of Bruxism. (Bruxism - is the medical term for the involuntary grinding, clenching, or gnashing of teeth. It can occur while awake or asleep, and often results in jaw pain, headaches, tooth wear, and sleep disruption.) In an interview with Resident #1 on 06/30/26 at 12:35 pm, Resident #1 stated that they have not been seen by a dentist since being admitted to the facility. Resident #1 stated that they have a history of grinding teeth. In an interview with the facility Director of Medical Records and Scheduler on 06/302/6 at 2:22 pm, the Director of Medical Records and Scheduler stated that the facility has a dental service that comes to the facility to consult with residents. The Director of Medical Records and Scheduler confirmed that Resident #1 has not been seen by a Dentist.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a medical record and all pertinent administrative records, and staff interview, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 1 (Residents #1) of 3 residents reviewed during a complaint survey.The findings include:Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in conditions that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles.During the review of Resident #1's electronic medical record on [DATE], it was discovered that Resident #1 had a physician's order, dated [DATE], to a Full Code. Further reviewe of Resident #1's paper clinical record revealed a MOLST form that indicated Resident #1 wanted to be a NO CPR, Option A-2, Do Not Intubate (DNI). Do not use any artificial ventilation. Do not give any blood products. Do not provide acute or chronic dialysis. In an interview with the facility administrator and the director of nurses on [DATE] at 4:30 pm, the facility administrative staff were made aware of the medical record issue.