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	11/26/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interviews, it was determined that the facility failed to store and process linens to prevent the spread of infection This was evident for 1 out of 1 observation made in the facility's laundry room. The findings include: On 11/25/2025 at 1:06 PM, an observation upon entering the laundry room hallway (which is a common hallway used by staff) revealed the door to the clean laundry room from the common hallway was propped open all the way, with a large fan in the doorway, which was on and faced the inside of the room (blowing air from the common hallway into the clean room). There were staff actively folding clean linen. Further observation at the same time revealed clean laundry (consisting of towels, reusable bed pads, comforters, sheets, resident gowns, and blankets) which was folded and stacked on an entire linen cart full (which was not covered). There was also clean linen folded and stacked on top of the linen cart across the width of the cart and approximately 3 layers high (all of the linen being exposed). In addition, in the same clean laundry room there was more of the same linen (consisting of towels, reusable bed pads, comforters, sheets, resident gowns and blankets) which covered an entire rectangular table width, stacked several layers high throughout the width of the table (ranging from 8 to 14 layers high). Several of the layers were stacked against the wall of the room. The entire table full of clean laundry which was stacked several layers high was exposed with no covering. On 11/25/2025 at 1:07 PM, an observation of the dirty laundry room revealed the ceiling had multiple vent tubings that extended across the room; the tubing was covered in layers of dust. On 11/25/2025 at 1:08 PM, an additional observation revealed that the door in between the dirty and clean room was propped open all the way, and the clean room where the several stacks of clean and folded exposed laundry were (on the rectangular table and linen cart), with no covering. There was an additional fan in the doorway between the dirty and clean room that was not on at the time of the observation. On 11/25/2025 at 1:13 PM, an interview with the Environmental Services Director (Staff #29) revealed that the expectation was that both doors (the door between clean and dirty room, as well as the main door from the common hallway to the clean laundry room) be shut at all times. She further indicated that the ventilation in the room was poor and the clean linen room can get hot so they prop open the door from the clean room to the dirty room as well as the other door from the common hallway into the clean room. She further indicated that the fans help with the poor ventilation as well so that the air circulated. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/2025 at 7:30 AM, the concern was reviewed with the Director of Nursing and she indicated that she understood.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews and medical record review it was determined that the facility failed to honor the resident's preferences of getting showers. This was evident for 1 (Resident #84) of 1 resident reviewed for choices during the survey. The Findings Include: On 11/20/2025 at 12:33 PM, Resident #84 expressed a concern that they had not received a shower since being moved to the second floor in early November. The resident stated that they have only been provided with bed baths and that a physical shower has not been done. On 1/21/2025 at 11:07 AM, review of the resident's Annual MDS from 2/3/2025, under section F- Preferences, revealed that during an interview with the resident for daily/activity preferences it is very important that the resident is able to choose how they are bathed. On 11/21/2025 at 11:36 AM, review of the second floor shower logs failed to reveal shower forms filled out for the resident in the month of November. On 11/21/2025 at 11:50 PM, in an interview with Staff #8, Geriatric Nursing Assistant (GNA), she stated that when a resident gets a shower the expectation of the staff is to complete a shower form and to put it in the shower log book. She also stated that if the shower form is not in the log book then the resident most likely did not get a shower. On 11/21/2025 at 11:55 PM, during an interview with the second floor Unit Manager, she stated that if a resident gets a shower the form is filled out and put into the shower log book. If the resident refused a shower it would be documented on the shower log and put into the log book or you would find it documented in the electronic medical records (PCC). At this time the surveyor revealed the concern that there were no forms filled out for resident #84 found in the Shower Log book. She stated that she would look into this concern and get back to the surveyor. On 11/24/2025 at 10:40 AM, during a follow up interview with the second floor Unit Manager, she stated that she was not able to find any proof that the resident had gotten a shower in the month of November.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that facility staff failed to ensure an advance directive was on file for a resident. This deficient practice was evident for 1 (#75) of 4 residents review for advance directive during the annual survey.The findings include: On 11/20/2025 at 1:43 PM, during an interview with the Director of Social Services (SW) #3, she stated that she began working at the facility October 2025. When asked about the process for newly admitted residents regarding advance directives, she explained that a resident should have an advance directive either prior to admission, at the time of admission, or be offered the paperwork during the care plan meeting. When questioned about Resident #75's advance directive, she stated she would follow up with her team to obtain the information. On 11/21/25 at 8:27 AM, a review of Resident #75's medical record revealed a social service assessment dated [DATE], in which the social worker documented that the resident has an advance directive on file. Further review of the resident's electronic and paper chart failed to show any evidence of an advance directive. At 8:30 AM, the surveyor requested evidence of an advance directive for Resident #75 from the Director of Nursing (DON). The DON stated that the social worker who completed the assessment was no longer employed at the facility as of October 2025, but she would search for the resident's advance directive. At 11:21 AM, during a review of the resident's electronic medical records, the surveyor observed a new social service progress note dated 11/21/25 at 8:43 AM. The note written by SW #3 indicated that attempts had been made to obtain an advance directive for Resident #75 and the facility has reached out to the resident's family member multiple times. To date, no response has been received. On 11/24/2025, the surveyor reviewed Resident #75s electronic medical record which showed that the DON upload an advance directive into the chart on 11/24/2025. The DON then provided the surveyor with a copy of the advance directive, signed on May 6, 2025, and acknowledged that the facility did not have an advance directive on file as previously documented in June 2025.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews, it was determined that the facility staff failed to provide evidence that a level 1 preadmission screening and resident review (PASARR) was completed prior to admission, or at the time of admission for a resident with a mental disability. This deficient practice was evident for one resident (#47) reviewed for PASARR during the annual survey. The findings include: The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening is referred to as Level I Identification of individuals with MD or ID and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identify individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility.On 11/20/2025 on 11:33 AM, during a review of Resident #47's medical records, the documents indicate that the resident was admitted to the facility November 2024 with multiple diagnosis including paranoid schizophrenia. Further review of the Resident's electronic medical records and paper medical records failed to show evidence of PASARR. On 11/20/2025 at 1:49 PM, during an interview with the Director of Social Services (SW) #3, the surveyor inquired about the facility's PASSAR process. She explained that PASSAR screenings are completed prior to admission and then annually. She then stated that she was recently hired and was unfamiliar with the facility's electronic medical record system and needed to speak with her team before providing additional information. At 2:30PM, the surveyor did not receive a response from the SW #3. At that time, the surveyor requested evidence of a PASARR for resident #47 from another staff member.On 11/21/2025 at 7:15 AM the surveyor received Resident #47s PASSAR. Review of the document revealed the PASSAR screen was completed by the Regional Social Worker on 11/20/25 at 2:52 PM.

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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 interviews and record reviews, it was determined that facility staff failed to ensure the resident's discharge planning needs were addressed and failed to follow up on the resident's request for discharge. This deficient practice was evident for one (#52) resident reviewed for discharge planning during the annual survey.The findings include:On 11/19/25 at 7:46 AM, during an interview with Resident #52, the resident expressed concerns about their discharge plans and stated that they had not participated in a care plan meeting in quite some time.Review of Resident #52s medical record on 11/19/2025 at 11:36 AM revealed a care plan conference note dated 07/31/25. The social worker documented that the care plan meeting was held with the resident and interdisciplinary team. During the meeting, the resident inquired about possibly being discharged at some point. The social worker noted that they would look into the waiver program for the resident.Further review of the records revealed a social services progress note dated 09/30/25, which failed to show any evidence that the social worker followed up with the resident regarding the discharge or the waiver program. On 11/20/25 at 2:30 PM, the surveyor requested evidence of Resident #52s housing waiver program status.On 11/21/25 at 8:19 AM, during an interview with the Director of Nursing (DON), the surveyor discussed the resident's 07/31/2025 care plan meeting. The surveyor noted that the social worker progress note date 09/30/25 did not appear to be a care plan conference meeting note since there was no documentation indicating that the resident attended the meeting or that the interdisciplinary team participated.The surveyor asked whether the facility maintains a care plan meeting log signed by staff and residents to identify attendees. The DON acknowledged that a log is used. The surveyor then requested to review the care plan meeting log for 09/30/25.On 11/24/25 at 7:20 AM, the DON provided the surveyor with the resident's care plan log dated July 2025. The form included a note indicating that the resident refused; however, the electronically documented care plan conference note in the resident's record showed that the resident was in attendance. The DON was unable to provide the list and signatures of attendees for 09/30/25 meeting. Additionally, the DON was unable to provide information regarding the resident's housing waiver program status.

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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 record review and interviews it was determined that the facility failed to conduct quarterly care plan meetings. This was evident for 2 (Resident #3 and Resident #52) out of 3 residents reviewed for care planning. The findings include: Care plan meetings are scheduled quarterly (every 3 months) discussions where the healthcare team and the resident or resident representative review the resident's current condition, discuss goals, and update the care plan to ensure it meets the residents needs. These meetings help everyone stay on the same track, address concerns, and coordinate appropriate, effective care. 1) On 11/19/25 at 7:46 AM, during an interview with Resident #52, the resident expressed concerns about their discharge plans and stated that they had not participated in a care plan meeting in quite some time. Review of Resident #52s medical record on 11/19/2025 at 11:36 AM revealed a care plan conference note dated 07/31/25. The social worker documented that the care plan meeting was held with the resident and interdisciplinary team. During the meeting, the resident inquired about possibly being discharged at some point. The social worker noted that they would look into the waiver program for the resident. Further review of the records revealed a social services progress note dated 09/30/25, which failed to show any evidence that the social worker followed up with the resident regarding the discharge or the waiver program. On 11/20/25 at 2:30 PM, the surveyor requested evidence of Resident #52s housing waiver program status. On 11/21/25 at 8:19 AM, during an interview with the Director of Nursing (DON), the surveyor discussed the resident's 07/31/2025 care plan meeting. The surveyor noted that the social worker progress note date 09/30/25 did not appear to be a care plan conference meeting note since there was no documentation indicating that the resident attended the meeting or that the interdisciplinary team participated. The surveyor asked whether the facility maintains a care plan meeting log signed by staff and residents to identify attendees. The DON acknowledged that a log is used. The surveyor then requested to review the care plan meeting log for 09/30/25. On 11/24/25 at 7:20 AM, the DON provided the surveyor with the resident's care plan log dated July 2025. The form included a note indicating that the resident refused; however, the electronically documented care plan conference note in the resident's record showed that the resident was in attendance. The DON was unable to provide the list and signatures of attendees for 09/30/25 meeting. Additionally, the DON was unable to provide information regarding the resident's housing waiver program status. 2) On 11/20/2025 at 9:27 AM, an interview with Resident #3 revealed that he/she had never had a care plan meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/2025 at 10:11 AM, record review revealed a progress note dated 04/16/2025 at 5:58 PM, which indicated the Resident #3's last care plan meeting was 04/16/2025. Further record review failed to reveal Resident #3 had a care plan meeting since 4/16/2025. On 11/24/2025 at 11:20 AM, the surveyor reviewed the findings during an interview with the Regional Social Worker (Staff #28) and she indicated that she would look into it. On 11/25/2025 at 8:13 AM, a follow up interview with the Regional Social Worker (Staff #28) revealed that there was no documentation of a care plan since 4/16/25 for Resident #3 and further indicated that if it was not documented then it was not done. On 11/26/2025 at 7:30 AM, the concern was reviewed with the Director of Nursing, and she indicated that she understood.

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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 observations, record reviews, and interviews, it was determined that the facility failed to maintain professional standards of practice by 1) ensuring a resident with congestive heart failure (CHF) had their weights adequately monitored, and 2) maintaining correct medication administration documentation. This deficient practice was evident for 1 (#75) of 1 resident reviewed for professional standards of practice and 2 (Resident #22 and #18) out of 6 residents observed for medication administration during the annual survey.The findings include: 1) On 11/19/2025 at 12:51 PM, a review of Resident #75s medical record showed that the resident was admitted in June 2025 with multiple diagnosis including CHF. Further review of the Treatment Administration Record (TAR) revealed an order initiated on 06/10/2025 for weekly weights every Wednesday. The record revealed that staff signed off that weights were obtained, but the weight section was marked with an x, indicating no weight was recorded on 10/01/2025, 10/08/2025, 10/15/2025, 10/22/2025, 11/05/2025, and 11/12/2025. A new weight order dated 11/18/2025 instructed staff to weigh the resident twice per week on Monday and Friday for CHF. Additionally, the resident's weight was also recorded on the vital signs section of the medical records, however, the dates recorded did not correspond with the dates recorded in the TAR. During an interview with the Unit Manager (UM) #4 on 11/21/25 at 9:39 AM, she stated that Geriatric Nursing Assistants (GNA) and Restorative Aides obtain residents weights, report them to the nurse, and the nurse documents the weights. The surveyor reviewed Resident #75s October and November 2025 TAR with the UM #4 and inquired about the missing weights. The UM #4 stated that the weights recorded on the TAR and vital signs section should correspond and was unable to provide an explanation for the discrepancy. On 11/21/2025 at 10:20 AM, the UM#4 provided the surveyor with a document of recorded weights for October 2025. The weight listed for Resident #75 also did not match the weight documented in the TAR. The surveyor then requested to speak with the staff member who recorded the weights on the form. On 11/21/2025 at 10:51AM, during an interview with the Restorative Aide (RA) #6, he explained that residents ordered for monthly weights were weighed on the first of the month, residents with CHF are weighed on Mondays and Fridays, and residents ordered for weekly weights are weighed on Wednesdays. He further stated that Resident #75 was originally on weekly Wednesday weights, but after the resident returned to the facility with a diagnosis of CHF, he began obtaining weights on Mondays and Fridays. The RA #6 stated that he could not recall when the resident weight order changed. The UM #4 was present during the interview, and the surveyor asked who is responsible for updating the residents' TAR. The UM stated that either she or the admitting nurse were responsible. The surveyor then asked why the TAR did not reflect the correct weigh schedule. The UM could not provide an answer. On 11/21/25 at 11:29 AM, the surveyor informed the Director of Nursing of the weight documentation discrepancies for Resident #75. 2a) On 11/25/2025 at 8:36 AM, an observation of Licensed Practical Nurse (Staff #15) perform medication administration revealed that Resident #22 refused Vitamin D and liquid protein that was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered and due at the time of the administration. On 11/25/2025 at 10:55 AM, record review of medication administration revealed that Staff #15 had documented (at the same time as the other medications that were administered at time of observation) that the resident refused not only Vitamin D and liquid protein, but Fluticasone Propinate 50 MCG/ACT suspension (a nasal spray), as well. However, the surveyor did not observe the nasal spray offered to nor refused by Resident #22. 2b) On 11/25/2025 at 9:18 AM, an observation of Licensed Practical Nurse (Staff #27) perform medication administration to Resident #18 revealed she prepared, Amlodipine 5mg (blood pressure medication), Colace 100mg (helps treat or prevent constipation), Bupren/nalox 12/13 mg film (helps treat strong pain medication addiction), Lamotrigine 25 mg (helps treat mood swings), and Lurasidone 40mg (helps treat mood swings). In total the LPN had administered 5 medications. On 11/25/2025 at 11:01 AM, record review of the administration record revealed that Staff #27 had documented (at the same time as the other medications that were administered at time of observation) that the resident refused Gabapentin Oral Tablet 600 MG (helps treat nerve pain), and Hi Cal (nutritional supplement). The surveyor did not observe Gabapentin nor Hi Cal offered to nor refused by Resident #18. On 11/26/2025 at 10:23 AM, the concern was reviewed with the Director of Nursing, and she indicated that she understood.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and medical record reviews, it was determined that the facility failed to provide treatment/services to maintain vision. This was evident for 1 (Resident #2) of 2 residents reviewed for vision during the survey. The Findings Include: On 11/19/2025 at 8:24 AM, during an interview with Resident #2, they stated that they had itchy scratchy eyes. They stated that they had not seen an eye doctor. On 11/21/2025 at 8:31 AM, a review of the resident's medical records revealed that on 6/6/2025 an order was placed for ophthalmology consult for decreased vision, on 9/4/2025 an order for an ophthalmology consult for an eye evaluation, and on 10/10/2025 there was an order placed for an ophthalmology consult. On 11/21/2025 at 9:12 AM, the medical provider visit notes were reviewed. The physician note on 5/28/25 stated that the resident requested to be seen by an ophthalmologist. The provider stated that an order would be placed. Physicians note from 9/4/25 stated that the resident was seen per nursing request related to seasonal allergies with itchy watery eyes and that consults would be ordered. The note on 10/10/25 stated that the resident complained of itchy watery eyes and the provider stated that they will consult an ophthalmologist. On 11/21/2025 at 1:45 PM review of ophthalmologist consult notes revealed that the resident has not been seen since 2/6/2025. On 11/24/2025 at 10:02 AM, during an interview with the second floor Unit Manager, she stated that the last time an ophthalmologist was in the facility to see residents was in October of 2025 and that Resident #2 had not been seen.