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

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined that the facility failed to obtain Resident #66 complete admission orders necessary for appropriate care. This was evident for 1 (Resident #66) out of 3 residents reviewed for hospitalizations.The findings include: On 05/11/2026 at 9:15 AM, Resident #66 was observed to have an indwelling foley catheter. Resident #66 stated that he/she utilizes a foley catheter at all times due to his/her paralysis. On 5/12/2026 at 12:48 PM, during a review of Resident #66's EMR (electronic medical record) the surveyor noted that Resident #66 was originally admitted to the facility on [DATE] with diagnoses including paraplegia, methadone dependence and neurogenic bladder requiring chronic catheterization. Further review of Resident #66's EMR revealed that Resident #66 was transferred to the hospital on [DATE] for an altered mental status. According to [hospital's] discharge summary, Resident #66 was diagnosed and treated during this hospitalization with intravenous antibiotics for acute pyelonephritis (bacterial infection of the kidney), severe sepsis (a life-threatening reaction to an infection) with bacteremia from MSSA (methicillin-susceptible Staphylococcus aureus) and ESBL (extended-spectrum beta- lactamase- enzymes that causes resistance to common antibiotics) proteus. Resident #66's EMR documented that Resident #66 returned to the facility on Saturday, 05/9/2026. On 05/12/2026 at 1:34 PM, continued review of Resident #66's EMR, in particular Resident #66's admission orders, which the regulations define as physician orders for the immediate care, lacked evidence of orders for: the care of Resident #66's indwelling foley catheter, the care of Resident #66's right upper extremity PICC (peripherally inserted central catheter) line, which was necessary for Resident #66 to be administered IV antibiotics, Enhanced Barrier Precautions as Resident #66 had two indwelling medical devices that qualify for enhanced barrier precautions, and the weekly laboratory tests necessary to monitor Resident #66 while being treated with IV antibiotics. Additionally, Resident #66's EMR lacked evidence of an order for Resident #66's maintenance methadone dose. The review of Resident #66's MAR (Medication Administration Record) documented Resident #66 receiving a dose of methadone on Monday, 5/11/26 at 10:56 AM. On 05/12/2026 at 2:58 PM, an interview with the Director of Nursing (DON) revealed that the facility typically did not admit residents on methadone on Fridays or Saturdays because the Wellness Director is not available to obtain the methadone for the resident from the community methadone clinics. DON stated, We did get Resident #66's methadone dose Monday [05/11/2026] so only Sunday's [05/10/2026] dose was missed. On 05/13/2026 at 2:35 PM, an interview with the DON confirmed that Resident #66's admission orders written on 05/9/2026 lacked orders for foley care, PICC line care, enhanced barrier precautions and weekly laboratory orders; all of which were essential to Resident #66's care.

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

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews and staff interviews, it was determined that the facility failed to complete a comprehensive assessment within 14 days of a significant change in the resident's condition. This was evident for 1 (Resident #11) of 6 residents reviewed for Minimum Data Set(MDS) assessments during the facility's recertification/ complaint survey. The findings include:The Minimum Data Set is a federally mandated, standardized assessment tool used in skilled nursing facilities to comprehensively assess a resident's clinical and functional status. The Minimum Data Set is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement.On 05/11/2026 at 10:55 AM, during the facility tour, the surveyor observed Resident #11's bed in the lowest position. During an interview with the resident, he/she stated that he/she had experienced a fall some time ago.On 05/13/2026 at 11:02 AM, review of Resident #11's electronic health record showed a nursing progress note dated 01/20/2026 revealed documentation stating: Status post unwitnessed fall. During unit rounds, the resident stated, ?I had a fall right there on the floor.' When asked what he/she was doing prior to the fall, the resident stated he/she was attempting to turn off the television. The resident reported attempting to transfer from the wheelchair to the bed. The resident denied pain and denied hitting his/her head during the fall. No injuries were observed at the time of assessment. Further review of the resident's change in condition documentation revealed X-ray results indicating a left intertrochanteric fracture. Documentation also revealed that the findings were reported to the physician, who ordered transfer to the Emergency Department (ED)for further evaluation. The resident denied pain during the assessment, and no facial grimacing was observed. Emergency Medical Services were contacted, and the resident was transferred to the hospital.On 05/13/2026 at 11:16 AM, review of the Minimum Data Set assessment dated [DATE] revealed the resident was assessed as having a significant change in condition.On 05/13/2026 at 1:44 PM, during an interview, the Minimum Data Set Coordinator stated the significant change assessment was completed because the resident experienced a fall on 01/19/2026, was transferred to the hospital on [DATE], and was diagnosed with a left hip fracture requiring surgery on 01/23/2026. The coordinator stated the resident returned to the facility on [DATE] with a decline in condition. When asked when the facility became aware of the resident's significant change and decline in condition, the coordinator stated the facility became aware upon the resident's return on 01/24/2026. When asked when the significant change assessment was completed, the coordinator stated it was completed on 02/19/2026.On 05/13/2026 at 1:49 PM, during a follow-up interview regarding the process for completing a Minimum Data Set significant change assessment, the coordinator stated the assessment should be completed as soon as the facility becomes aware of the significant change, or within 14 days of the change. When informed the assessment was not completed within the required timeframe, the coordinator acknowledged the concern.On 05/14/2026 at 12:40 PM, the concern was discussed with the Director of Nursing (DON), who acknowledged the findings.

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	215085	A. Building B. Wing	05/15/2026

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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 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 (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	215085	A. Building B. Wing	05/15/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined that the facility failed to implement a care plan with interventions regarding Resident #66's indwelling catheter. This was evident for 1 (Resident #66) out of 1 residents reviewed for urinary catheter. The findings include: On 05/11/2026 at 9:15 AM, during screening Resident #66 was observed to have an indwelling foley catheter. Resident #66 stated that he/she utilizes a foley catheter all the time and his/her foley catheter was changed during his/her recent hospitalization. On 5/12/26 at 12:48 PM, during a review of Resident #66's EMR (electronic medical record) the surveyor noted that Resident #66 was diagnosed with paraplegia and neurogenic bladder requiring chronic catheterization. Review of Resident #66's most recent hospitalization discharge summary documented that Resident #66 was transferred from the facility on 5/2/26 to the hospital, where Resident #66 was diagnosed with acute pyelonephritis (bacterial infection of the kidney), severe sepsis (a life-threatening reaction to an infection) with bacteremia from MSSA (methicillin-susceptible Staphylococcus aureus) and ESBL (extended-spectrum beta- lactamase-enzymes that causes resistance to common antibiotics) proteus. Resident #66 was discharged back to the facility on [DATE]. Further review of Resident #66's EMR revealed that Resident #66's care plan, which was updated as recently as 05/11/2026 did not address or have any interventions for Resident #66's indwelling foley catheter care to prevent a recurrence of a urinary tract infection and pyelonephritis. On 05/13/2026 at 2:35 PM, Director of Nursing confirmed that Resident #66's care plan lacked any reference to his/her indwelling catheter and the necessary care to prevent urinary tract infections.

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	215085	A. Building B. Wing	05/15/2026

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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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	215085	A. Building B. Wing	05/15/2026

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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.

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	215085	A. Building B. Wing	05/15/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to have the provider respond to Medication Regimen Review recommendations in a timely manner. This was evident for 3 (Resident #2, #8 and #63) out of 5 residents reviewed for unnecessary medications.Facility 's Medication Regimen Review (MRR) Policy and Procedure. It is the policy of this facility that each resident's medication regimen shall be reviewed by a qualified consultant pharmacist at least monthly, and more frequently as clinically indicated, to identify medication irregularities, unnecessary medications, adverse outcomes, monitoring deficiencies, and opportunities for optimization.POLICY STANDARDS: 1. Every resident shall receive a monthly medication regimen review. 2 Medication irregularities shall be promptly reported. 3. Provider responses shall be documented. 4. Recommendations shall be tracked through resolution. (reviewed November 2025) The findings include: (1) On 5/11/2026 at 1:38 PM, record review revealed that Resident #8 had an active order for Quetiapine (antipsychotic medication) 400 mg. On 5/12/2026 at 11:28 AM, review of medication medication regimen review dated 2/9/2026 revealed that the consultant pharmacist recommended decreasing Quetiapine from 400 mg to 300 mg. The recommendation was signed by both the pharmacist and physician. Further record review of discontinued medications revealed no evidence that an order had been processed or implemented to decrease the dosage, and Resident #8 remained on an active order for Quetiapine 400 mg. On 5/13/2026 at 8:25 AM, an interview with the Director of Nursing revealed that the expectation was that once a physician accepted the pharmacist's recommendation, staff would process and submit the corresponding order. On 5/15/2026 at 8:34 AM, the concerns were addressed with the Director of Nursing and she indicated that she understood. (2) On 5/12/2026 at 10:30 AM, 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 on 03/05/2026 the Consultant Pharmacist (Staff #21) recommended review of Resident #2's five psychotropic medications for eligibility for a GDR (Gradual Dose Reduction). On 05/12/2026, after surveyor intervention, Facility Physician (Staff #20) responded to the Pharmacist recommendation from three month prior stating Follow up with the Psychiatrist for GDR. On 5/13/2026 at 8:25 AM, During an interview the Director of Nursing (DON) stated that the unit managers are suppose to review and follow up on pharmacist recommendations. The DON stated that because the facility had vacancies for unit managers, DON would now be assuming that role as well until unit managers were in place in the facility. The facility failed to respond to Resident #2's 03/05/2026 MMR recommendation in a timely manner (continued on next page)

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	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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and failed to track the recommendation through to resolution. (3) On 5/12/2026 at 12:26 PM, a review of Resident #63's records was conducted. Resident #63 had a Medication Regimen Review (MRR) with irregularities or recommendations after pharmacist review on 1/7/2026 and 5/6/2026. This surveyor requested the pharmacist's note for both dates from the Director of Nursing, as they were not available in the resident's chart. On 5/12/2026 at 2:10 PM, a review of Resident #63's MRR was conducted. In the 1/7/2026 MRR, the pharmacist recommended that Hydroxyzine to be discontinued or replaced because it is a highly anticholinergic antihistamine. The provider checked other (out of the agree, disagree, and other box) and documented, Follow up with the Psychiatrist for GDR. The provider signed their response on 5/12/2026 (4 months after the recommendation). On 5/12/2026 at 2:12 PM, a review of the facility's MRR policy was conducted. No specific timeframes for response times from the pharmacist or the provider were in the policy. On 5/12/2026 at 2:23 PM, an interview with the Administrator was conducted. The surveyor expressed concern with the delay in physician review of the MRR and expressed concern with no timeframes of responses (physician or pharmacist) in the MRR policy. The administrator agreed with the concern.

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	215085	A. Building B. Wing	05/15/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and observation, it was determined that the facility did not ensure that enhanced barrier precautions were maintained while Resident #28 received wound care on 05/12/2026. This was evident for 1 (Resident #28) out of 2 residents reviewed for pressure ulcers. The findings include: Facility's Enhanced Barrier Precautions (EBP) Policy and Procedure. Enhanced Barrier Precautions are intended to reduce transmission of multidrug- resistant organisms through the appropriate use of gowns and gloves during high-contact resident care activities for residents at increased risk of transmission. Multidrug-Resistant Organisms (MDRO): Organisms resistant to multiple antimicrobial agents, including but not limited to: MRSA, VRE, ESBL-producing organisms, CRE, Candida auris and other organisms identified by public health authorities. High-Contact resident care activities requiring gown and gloves- Staff shall wear gown and gloves during the following care activities for qualifying residents: dressing assistance, bathing or showering. wound care. (reviewed November 2025) On 05/11/2026 at 2:15 PM, during a review of Resident #28's EMR (electronic medical record) the surveyor noted that Resident #28 was ordered on 12/8/2025 by MD 20 Enhanced Barrier Precautions for CRE (Carbapenem- Resistant Enterobacterales- a family of bacteria that is highly resistant to many antibiotics), foley, wound and enteral feedings q (every) shift for precautions. On 5/12/26 at 10:12 AM, while observing Resident #28's wound performed by the Wound Care Nurse Practitioner (Staff #22) the surveyor noted that Staff#22 did not use the yellow isolation gown that is required for enhanced barrier precautions when providing high-contact resident care activities. On 5/12/26 at 2:20 PM, during an interview with the Director of Nursing (DON), a surveyor informed the DON of the observation of Resident #28's wound care without the appropriate PPE (personal protective equipment).The DON stated that Resident #28 is colonized for resistant infections and PPE should be worn with high-contact care.