STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215118	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Old Court	5412 Old Court Road Randallstown, MD 21133

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 51128 Based on reviews of a facility reported incident, interviews, and record review, it was determined that a staff member had removed money from a resident's account without permission. This was evident for 1 of 36 facility reported incidents reviewed during an annual recertification survey. The findings include: On 12/06/2024 at 12:09 PM, a review of the facility-reported incident, MD00183120, reported on 11/16/2022, revealed an allegation of misappropriation of funds. Resident #23 reported that she/he did not have his/her checkbook. Resident #23's daughter reported that two checks had cleared Resident #23's account, one for $600 and another for $400. Resident #23's bank confirmed that the name on the two checks was Geriatric Nursing Assistant (GNA) #32. The facility confirmed that GNA#32 worked as an agency GNA on 11/16/2022 on 7-3 and 3-11 shifts. The investigation conducted by the facility determined that two checks totaling $1000 were written to GNA #32 and were cashed. Resident #23's bank blocked her/his account and reimbursed Resident #23. The Nursing Home Administrator (NHA) was interviewed on 12/06/2024 at 2:16 PM. The NHA stated that the facility conducted a thorough investigation and provided the information to the staffing agency. On 12/06/2024 at 02:30 PM, an interview was conducted with the staffing coordinator (Staff # 22), who stated that the background checks and training are reviewed on the agency's portal. When asked about the most recent abuse training for GNA #32, she stated that GNA#32 was a DNR Do Not Return to the facility but was able to provide a copy of the training. GNA #32's abuse training was dated 5/19/2021, which was outdated at the time of the incident. On 12/12/24 at 08:30 AM, the surveyor discussed concerns with NHA concerning the outdated abuse training and the failure to protect Resident #23 from misappropriation of resident property.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49148 Based on record review and interview with staff, it was determined that the facility failed to timely report an allegation of abuse to the State Agency, the Office of Health Care Quality (OHCQ), immediately but not later than 2 hours after the allegation of abuse was made. This was evident for 2 (Resident #34 and #147) out of 15 residents investigated for abuse during the survey. The findings include: 1) On 12/5/2024 at 1:45PM, the Surveyor reported an allegation of abuse which involved Resident #34 to the Nursing Home Administrator (NHA) #1. On 12/6/2024 at 11:38AM, the NHA #1 provided the Surveyor with the Facility Reported Incident (FRI) initial report form for the abuse investigation. During a review of the FRI document, the Surveyor discovered that the report was completed on 12/6/2024 at 9:45AM and not within the two-hour timeframe. During an interview with NHA #1 and Regional Nurse #3 on 12//6/2024 at 1:40PM, the Surveyor confirmed that the FRI initial report form was not completed within the two-hour timeframe of the abuse allegation. 42863 2) On 12.06.24 at 2:00 PM the surveyor reviewed MD00202200, a facility reported incident (FRI) for Resident #147 related to alleged employee to resident sexual abuse. Per the documentation in the FRI, the facility staff became aware of the incident on 02.04.24 at 9:50 PM. Also, per the facility report the Administrator, Staff #2 was notified of the incident on 02.04.24 at 10 PM by the former director of nursing, (DON) #38. Resident #147 reported to the staff that he/she felt sharp pain near [his/her] vagina and alleged that [Staff # 34] maybe put his finger in there during incontinence care. The Resident had a Brief Interview for Mental Status (BIMS) score of 15. According to the FRI there were no facility staff witnesses, and Resident #147 was not found to have any injuries at the time of the incident on 02.04.24 when examined by a female nurse. On 12.07.24 at 2:30 PM the surveyor reviewed the hard copy of the facility incident report folder provided by the facility. The administrator, Staff #1 documented in the initial facility report was submitted on 02.05.24 at 11:30 PM which was more than 2 hours after the knowledge by staff of the abuse allegation. Additionally, the administrator documented that the resident representative and the medical director were notified on 02.05. 24. On 12.09.24 at 1:40 PM the DON and Administrator were advised that the surveyor required a copy of the full FRI documents related to MD00202200. The facility had determined the allegations were not substantiated per the documentation in the hard copy FRI. The surveyor discussed the concern regarding the timely submission of the FRI to the OHCQ department. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12.12.24 at 1:00 PM the surveyor discussed the concerns again with the Administrator regarding the late submission of the initial facility incident report.

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 51128 Based on a review of a Facility Reported Incident, resident interview, and staff interviews, it was determined that the facility failed to ensure that the agency Geriatric Nursing Assistant (GNA) had received the annual abuse education required to work with long-term care residents. This was evident for 1 (staff #32) of 3 GNAs reviewed for abuse education during the survey. The findings included: During an interview on 12/05/24 at 12:58 PM with Resident #23, the resident's daughter stated there had been an incident of missing checks. Upon further questioning, Resident #23's daughter stated that a GNA had stolen and cashed two checks, but the funds were reimbursed. On 12/06/24 at 11:50 AM, the Surveyor requested the Facility Reported Incident for the above incident. On 12/06/2024 at 12:09 PM, a review of the facility-reported incident, MD00183120, reported on 11/16/2022, revealed an allegation of misappropriation of funds. Resident #23 reported that she/he did not have his/her checkbook. Resident #23's daughter reported that two checks had cleared Resident #23's account, one for $600 and another for $400. Resident #23's bank confirmed that the name on the two checks was GNA #32. The facility confirmed that GNA#32 worked as an agency GNA on 11/16/2022 on 7-3 and 3-11shifts. The investigation conducted by the facility results determined that two checks totaling $1000 were written to GNA #32 and were cashed. Resident #23 s bank blocked her/his account and reimbursed Resident #23. On 12/06/2024 at 2:16 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated that the facility conducted a thorough investigation and provided the information to the staffing agency. In addition, the NHA stated that prior to agency staff working at the facility, the facility staffing coordinator would look up agency staff training and background checks on the agency's portal. The facility staffing coordinator (Staff #22) was interviewed on 12/06/2024 at 2:30 PM. She stated that the agency staff's credentials, background checks, and training were on the agency's portal. Staff #22 provided a printout of GNA# 32's abuse training, signed and dated 5/19/2021. It was noted that the GNA abuse training was overdue for the annual education requirement. The surveyor requested any documentation to support GNA #32, who received abuse, neglect, and misappropriation training annually. However, the facility staff confirmed that GNA #22 did not have additional training records prior to the above incident. On 12/12/2024, NHA was made aware that this was a concern.