STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215147	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Northpoint	1046 Old North Point Road Baltimore, MD 21224

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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 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. Based on surveyor observation, review of the medical record, and interviews with facility staff, it was determined that the facility staff failed to ensure that advance directives were discussed with residents and/or responsible representatives and ensure that a current copy of residents' advanced directives were in the residents' medical record. This was evident for 6 (Resident #130, #74, #47, #20, #189, and #95) out of 47 residents reviewed during the recertification survey. The findings include: An advance directive is a legal document outlining a person's wishes for medical care should they become unable to make decisions for themselves because of illness, injury, or incapacity. It allows individuals to specify their preferences for treatment, including life-sustaining measures, and to appoint a healthcare agent to make decisions on their behalf. Essentially, it is a way to ensure your healthcare preferences are followed, even when you cannot communicate them directly. On 6/16/25 at 11:55 AM review of Resident #74's medical record failed to reveal an advance directive. On 6/16/25 at 11:56 AM review of Resident #130's medical record failed to reveal an advance directive. On 6/16/25 at 11:57 AM review of Resident #47's medical record failed to reveal an advance directive. On 6/16/25 at 11:58AM in an interview with Unit Manager #7 when asked where advanced directives are kept, she stated if we have them, because we do not have them for everybody, it would be in their paper chart and scanned into the documents tab of PCC (Point Click Care), the facility's electronic medical record (EMR). On 6/16/25 at 1:32 PM review of Resident #20's medical record failed to reveal an advance directive. On 6/16/25 at 2:32 PM review of Resident #189's medical record failed to reveal an advance directive. On 6/16/25 at 2:34 PM review of Resident #95's medical record failed to reveal an advance directive. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 12:46 PM in an interview with the Social Services Director (SSD #9) when asked about the process for advanced directives, she stated that on admission every resident is asked if they have an advanced directive. During the interview, SSD #9 stated every new admission is offered to complete an advanced directive during the admission process. Additionally, she stated, if they want to do one, they do it with them, give them a copy, put it in their paper chart, and then upload a copy into PCC. For the Long Term Care residents, if they do not already have one, staff should offer one quarterly and complete it with them if they want, and they will also do one upon request. When asked if during the admission process, the resident and/or resident representative stated they have an advance directive, what she does, SSD #9 stated, we ask them to bring in a copy so we can have it in the facility. When asked if she followed up if they have not provided a copy, SSD #9 stated yes and if she had not seen it by the care plan meeting, about 2 weeks after admission, she would ask again at that time. Additionally, she stated she would try to follow up again after that care plan meeting and that all those conversations should be documented as a social services note or an advanced directive note. On 6/17/25 at 12:52 PM the surveyor requested a copy of Resident #130's advance directive. On 6/17/25 at 12:55 PM SSD #9 stated she did not have an advanced directive on file for Resident #130. On 6/17/25 at 1:00 PM, the surveyor requested a copy Resident #74, Resident #47, Resident #20, Resident #189, and Resident #95's advance directive and documentation from the medical record where advanced directives were discussed. On 6/17/25 at 2:26 PM in an interview with SSD #9, she stated that she did not have documentation of discussions on admission regarding advance directives with Resident #130 or Resident #74. During the interview, she stated she did not have a copy of Resident #74's advance directive in his/her medical record. Furthermore, she stated that Resident #20, Resident #189, and Resident #95 were not offered to formulate an advance directive upon admission, but after surveyor intervention, she went and offered one and documented what they each said. On 6/17/25 at 2:35 PM the surveyor shared the concerns regarding advance directives and SSD #9 verbalized and confirmed understanding of the concerns.

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	215147	A. Building B. Wing	06/27/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on surveyor observation and interviews with residents and facility staff, it was determined that the facility failed to ensure a clean, comfortable, and homelike environment as evidenced by a heavily soiled privacy curtain. This was evident for 1 (Resident #67) of 7 residents reviewed during the investigation phase of the facility's recertification survey. The findings include: On 6/23/25 at 9:08 AM in an interview with Resident #67, s/he stated the privacy curtain was dirty and s/he had asked them to change it. During the interview, s/he also stated that in his/her previous room, the curtain became soiled and was not changed for months. S/he stated that in both instances, various facility staff verified it was soiled and dirty and still it was not changed timely. On 6/23/25 at 9:34 AM during dual observations with both the Regional Mobile Director of Nursing (RMDON#26) and Licensed Practical Nurse (LPN #18) they observed and verified Resident #67's privacy curtain was dirty and soiled with brown marks all over it. When asked if that is how a resident's curtain should look LPN #18 stated, no ma'am it is not appropriate. The surveyor shared the concerns with RMDON #26 who stated she would have housekeeping come and change it.

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	215147	A. Building B. Wing	06/27/2025

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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. Based on interview and record review it was determined the facility staff failed to report an allegation of abuse within 2 hours of the allegation and failed to report the results of all investigations within 5 working days of the incident, to the State Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #194) of 47 residents reviewed during a recertification survey. The findings include: On 6/17/2025 at 7:50 AM during initial pool screen, Resident #194 reported to the surveyor that the Aide [Geriatric Nursing Assistant (GNA)] who worked on the night shift was very rough while changing her/him. The resident stated that when s/he asked the Aide to stop, the Aide said, How am I going to get this diaper into your creases. When asked if the resident told anybody about this, Resident #194 stated s/he told the night nurse that the Aide was rough and mean. On 6/17/2025 at 8:15 AM Surveyor informed the Unit Manager (UM #7) about Resident #194's allegations of abuse by a nightshift GNA. UM #7 stated that she was not aware of the above allegation. However, UM #7 stated she was going to talk to Resident #194 and follow up with staff. On 6/18/2025 at 7:30 AM, in an interview with UM #7, when asked if the initial self- report was submitted to OHCQ, UM #7 stated she did not know but would follow up with the Director of Nursing (DON), who according to UM #7, was aware of the allegation of abuse. On 6/18/2025 at 8:29 AM, in a follow up interview with UM #7, she stated they did not do a self-report because they did an investigation and Resident #194 did not feel it was intentional. UM #7 added that Resident #194 stated s/he felt the GNA was just rushing to do her (GNA) task. On 6/18/2025 at 8:56 AM, in an interview with the DON, she stated that the expectation was to submit a self-report to OHCQ within 2 hours of any allegation of abuse. When asked if the facility submitted an initial self-report of the above allegation of abuse to OHCQ, the DON stated that a self-report was not submitted to OHCQ because during their investigation Resident #194 stated s/he felt the GNA did not do anything with a malicious intent. When asked about when to submit the final investigation report to OHCQ, DON stated 5 days. On 6/26/2025 at 9:15 AM, a follow up interview was conducted with the DON in the presence of the Nursing Home Administrator (NHA). DON confirmed that the facility did not submit an initial self-report within 2 hours and/or their final investigation report within 5 working days required by regulation of any allegation of resident abuse. Thus, failing to report an allegation of resident abuse to the State Survey Agency (OHCQ). On 6/26/2025 at 9:52 AM, a review of the record of the facility investigation report of the above allegation of abuse failed to reveal that facility staff reported the allegation to the appropriate agencies required by regulation. On 6/27/2025 at 1:50 PM, during the exit conference with the NHA, DON, and corporate staff, no further information was provided to validate the reporting of an alleged abuse.

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	215147	A. Building B. Wing	06/27/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative in writing about the bed hold policy when the resident was transferred/discharged from the facility to an acute care facility. This was evident for 1 (Resident #56) of 2 residents reviewed who were transferred to an acute care facility during the recertification/complaint survey. The findings include: Review of the medical record for Resident #56 on 06/26/25 12:55 PM revealed that the Resident #56 was admitted to the facility on [DATE] and was sent to an acute care facility on 06/23/25 for a change in his/her medical condition. Further review of the medical record failed to produce written evidence that the Resident and/or the Resident representative were given written notice of the bed hold policy. The facility's documentation on change in condition transfer form, nurse's progress notes, and the eINTERACT SBAR Summary dated 6/23/2025 23:03 revealed that the bed hold policy was not given to the resident and/or the Resident representative. On 06/26/25 at 02:10 PM, in an interview, Licensed Practical Nurse (LPN) staff #43 revealed that the Bed hold policy is signed by the Nurse in charge, and sent it off to the hospital after notifying the family. On 02/26/25 at 2:30 PM, during the review with the Director of Nursing (DON), it was revealed that a copy of the bed hold policy was provided when the Resident was sent out to the hospital; however, he/she could not produce written evidence that the Resident # 56, or the Resident representative, was given written notice of the bed hold policy.

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	215147	A. Building B. Wing	06/27/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on complaint reviews, medical record review, and staff interview, it was determined that the facility failed to provide needed activities of daily living (ADL) for a resident dependent on bathing assistance. This was evident for 1 (Resident #386) of 15 complaints reviewed during the survey. The findings include: Review of complaints MD00214746 and MD00213586 on 06/17/25 revealed allegations that Resident #386 was not receiving showers or baths. On 06/23/25 at 2:20 PM Resident #386's closed medical record was reviewed and revealed Resident #386 was admitted to the facility in March 2024 with a history of having seizures, muscle weakness, and osteoarthritis. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of the admission MDS assessment with an assessment reference date of 6/28/23 documented that Resident #386 was dependent on staff for bathing. Review of Resident #386's GNA (geriatric nursing assistant) Kardex documented Resident #386 was assigned to receive showers on Mondays and Thursdays. Review of Resident #386's ADL's documented that resident did not receive any showers in January 2025 from 01/01/25 to 01/31/25. There was no documentation Resident #386 had a bed bath or had refused bathing or a shower. On 06/24/25 at 2:22 PM, an interview was conducted with Corporate Director of Nurses #25, who stated confirmed that Resident #386 did not receive a shower or bath in January 2025 and that the nursing staff did not document Resident #386 had refused a bath or shower in January 2025.

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	215147	A. Building B. Wing	06/27/2025

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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 the surveyor's observation, medical record review, and interview with facility staff, it was determined that the facility failed to administer medication as ordered by the physician and sanitize or wash hands before the administration of medication. This was evident for 1 (#83) of 3 Residents reviewed for medication administration via gastrostomy tube, during the recertification survey. The findings include: On 06/26/25 at 8:30 AM, Review of Resident #83's medical records revealed the resident was admitted to the facility on [DATE] and was receiving long-term care. The physician ordered: 1. Aspirin 81 mg, one tablet via G Tube one time a day. 2. Polyethylene Glycol powder, give 17 grams enterally, one time a day for bowel regimen and hold for loose stool. 3. Theragran-M tablet, give one tablet via G tube, one time a day as a supplement. 4. Proheal liquid protein, two times a day for supplement, 30 ml via peg tube. 5. Captopril tablet 25mg, give one tablet via G tube, every eight hours, for hypertension. Medications #1 through #5 were scheduled to be administered at 9 AM daily via gastrostomy tube. A gastrostomy tube is a feeding tube inserted through the abdominal wall directly into the stomach, providing a way to deliver nutrition, fluid, and medications when a person is unable to eat or swallow adequately. On 06/26/25 at 10: 45 AM, the Surveyor observed Registered Nurse (RN) # 44 administered medications #1 through #5 to the Resident #83 via gastrostomy tube. The surveyor also observed RN #44, administered the medications via G Tube, without changing the gloves after touching the faucet in the resident's bathroom and after touching the Resident's bed control. On 06/26/25 at 10:05 AM, an Interview with the RN #44 revealed that the administration of the medication can be done one hour before or one hour after the scheduled time. However, administration was further delayed because a Certified Medicine Aide (CMA) was not scheduled to work, who assisted with medication administration. The surveyor reviewed with the RN #44, and he/she agreed with the surveyor's observation that he/she failed to administer the medication at the scheduled time, and did not change gloves or wash hands after touching bathroom faucets and bed controls, before administering medication. On 06/26/25 at 11:11 AM, the concern was reviewed with the Regional staff #25 who acknowledged the concern.

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	215147	A. Building B. Wing	06/27/2025

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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 observation, medical record review and staff interview, the facility failed to provide treatment/services to maintain vision. This is evident for 1 out of 8 residents (Resident #38) selected for review during the investigation stage of the survey process. The findings include: On 06/16/25 at 08:15 AM during the screening process of the survey, the surveyor observed Resident #36 eating breakfast with eyes closed, not wearing glasses, and feeling with hands for food items. During an interview on 06/16/25 at 12:45 PM, surveyor asked the resident if they has difficulty seeing, and resident replied yes. The resident was opening and closing eyes during the interview and was not making eye contact. Review of the resident's medical record on 06/16/25 at 12:58 PM revealed the resident MDS (Minimum Data Set) assessment on May 21, 2025, at 07:39AM in section B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) identified Resident as Impaired. B1200. Corrective Lenses Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000 marked, yes. On 06/18/25 at 09:03 AM review of the orders written on 4/3/2023 indicated ophthalmology eval test and treat PRN (as needed). Review of the health drive eye care group eye exam on 1/8/2024 noted a plan to Monitor; follow: Priority Comprehensive 3/30/2024 and recall: comprehensive 3/30/2024. An interview was conducted on 06/18/25 at 08:55 AM with Director of Nursing (DON) about the process for eye exams. The DON stated that a service provider who examined the resident and would follow up with further exams. The surveyor asked how the facility knew that the follow-up comprehensive eye exam was provided. DON stated that service provider provided a list of residents to be seen in the upcoming months. DON also stated that she would call service provider to see if Resident #38 was seen for follow-up care. On 6/20/2025 at 1:50 PM, the Administrator informed the surveyor that Resident #38 was now scheduled for an eye appointment. The surveyor explained that this appointment was obtained after surveyor's intervention and that was a concern. The surveyor also added that Resident #38 was supposed to have a follow up eye exam back in March 2024. The Administrator agreed.

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	215147	A. Building B. Wing	06/27/2025

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Future Care Northpoint	1046 Old North Point Road Baltimore, MD 21224

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review, resident and staff interviews, it was determined the facility staff failed to ensure that a resident was given pain medication consistent with professional standards of practice. This was evident for 2 (#131, #189) of 2 residents reviewed for pain management during the survey. The findings include: 1) During an initial pool screen of Resident #131 on 6/16/2025 at 9:15 AM, the resident complaint of pain rating it at 10/10 to the back of his/her neck going down their back. Resident #131 further stated that the staff did not give them pain medications regularly and were making him/her wait for long periods. Review of Resident #131's clinical records on 6/18/2025 at 8:00 AM revealed the resident was re-admitted to the facility in June 2025 with medical diagnoses that include but not limited to acquired absence of other left toe(s) encounter for orthopedic aftercare following surgical amputation, type 2 diabetes with other skin complications, bacteremia, unspecified atrial fibrillation, need for assistance with personal care. On 6/18/2025 at 8:09 AM, a review of physician orders revealed the following active orders: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl). Give 1 tablet by mouth every 6 hours as needed for Pain, start date 6/13/2025. Of note, there were no parameters/pain scale indicated for administration of this PRN (as needed) pain medication. There were also discontinued orders for: PRN Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain 6-10, start date 6/2/2025 and discontinued on 6/9/2025, On 6/18/2025 at 10:56 AM, record review revealed that Resident #131's pain was not managed consistently. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2025 was completed. Staff documentation revealed that the resident was given: PRN Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain 6-10 was given outside ordered parameters on 6/5/2025 at 1901 (7:01 PM) for pain score of 0. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), Give 1 tablet by mouth every 6 hours as needed for pain (of note, there were no parameters indicated for administration), was given for a pain score of 0 on 6/14/2025 at 2111 (9:11 PM) and On 6/15/2025 at 1715 (5:15 PM), pain score was 0. Staff did not document any non-pharmacological interventions (NPIs) attempted prior to the PRN pain med administration. (continued on next page)

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	215147	A. Building B. Wing	06/27/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/23/2025 at 1:34 PM, in an interview with the Director of Nursing (DON), she stated that PRN pain meds should be given following physician orders. Regarding non-pharmacological interventions (NPIs) prior to PRN pain med administration, DON stated that NPIs were imbedded in the resident's care plan and ideally staff were expected to document in their progress notes that they attempted NPIs prior to PRN pain med administration. However, she added that staff did not usually document in their progress notes that they attempted NPIs. Surveyor also reviewed with the DON Resident #131's MAR and TAR for June 2025 regarding staff not following ordered parameters for PRN pain med administration. DON stated that the pain medications should be given according to doctor's orders. Surveyor reviewed resident's Oxycodone that was ordered PRN without parameters. DON stated that it was not appropriate to give Oxycodone for a pain score of 0. 2) On 6/17/2025 at 8:45 AM in an interview with Resident #189, s/he stated that her/his pain was not well managed in the facility. S/he described the pain as chronic dull pain that was sometimes throbbing and rated it at 10+/10 to their right hip and head. Resident #189 added that s/he was constantly in pain. Review of Resident #189's clinical records on 6/20/2025 at 10:06 AM revealed the resident was admitted to the facility in June 2025 with medical diagnoses that include but not limited to urinary tract infection, idiopathic aseptic necrosis of right femur, low back pain, atrial fibrillation, muscle weakness, unspecified abnormalities of gait and mobility, legal blindness. On 6/20/2025 11:04 AM Review of physician orders revealed the following active orders: Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Breakthrough pain 7-10, start date 6/17/2025 Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for Pain 2 tabs to make 1000 mg, start date 6/5/2025. Of note, there's no ordered parameters/pain scale indicated for PRN pain medication administration. Further review of physician orders revealed the following discontinued/completed orders: Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 12 hours as needed for Breakthrough pain, ordered 6/5/2025 and discontinued on 6/17/2025 Of note, there was no ordered parameters/pain scale for this PRN pain medication. On 6/20/2025 at 11:28 AM, record review revealed that Resident #189's pain was not managed consistently. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2025 was completed. Staff documentation revealed that the resident was given: PRN Acetaminophen 500mg (2 tabs) ordered without parameters for pain management was given for pain scores ranging from 0 to 8. (continued on next page)

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	215147	A. Building B. Wing	06/27/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/2025 at 0217 (2:17 AM), pain score was 5; On 6/15/2025 at 2306 (11:06 PM), pain score was 0; and On 6/18/2025 at 2045 (8:45 PM) pain score was 8. Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 12 hours as needed for Breakthrough pain. (Of note, no ordered parameters for PRN pain med administration) was given for pain score of 0 on 6/10/2025 at 0106 (1:06 AM). Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Breakthrough pain 7-10 was given outside ordered parameters on the following dates/times: On 6/19/2025 at 1717 (5:17 PM) for pain score of 6. On 6/20/2025 at 0758 (7:58 AM) for pain score of 4. More so, there was no documentation of non-pharmacological interventions attempted prior to PRN pain med administration. On 6/23/2025 at 1:26 PM, in an interview with the Director of Nursing (DON), she stated that PRN pain medications should be given according to physician orders. Regarding non-pharmacological interventions (NPIs) prior to PRN pain medication administration, DON stated that NPIs were imbedded in the resident's care plan and ideally staff were expected to document in their progress notes that they attempted NPIs prior to PRN pain med administration. However, she added that staff did not usually document in their progress notes that they attempted NPIs. Surveyor reviewed with the DON Resident #189's MAR and TAR for June 2025 regarding pain management and staff not following ordered parameters for PRN pain med administration. DON reviewed and validated surveyor's findings. On 6/27/2025 at 8:05 AM, an interview was conducted with Licensed Practical Nurse (LPN #18). Regarding administration of PRN pain medications, LPN #18 stated that prior to giving any pain medication, she will assess the resident's pain and choice of pain medication to be given will be based on physician orders/ordered parameters. She stated that each PRN pain medication order must have a pain scale/parameters for administration: Tylenol for pain score 1-5 and any narcotic such as Oxycodone for pain score of 6-10. LPN #18 stated that ordered parameters for PRN pain medications should always be followed. She further stated that she would not administer Tylenol for pain score of 8 unless the resident requested it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215147	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Northpoint	1046 Old North Point Road Baltimore, MD 21224

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of staff records and interviews with facility staff, it was determined that the facility failed to conduct annual performance reviews of Geriatric Nursing Assistants (GNAs). This was evident for 1 (GNA #34) of 2 randomly selected GNAs' employee files reviewed during the facility's recertification survey. The findings include: Performance reviews are to be completed for every GNA at least every 12 months to identify in-service education based on the outcome of those reviews. On 6/26/25 at 9:46 AM, the employee files of 2 GNA's were reviewed during the staffing facility task. During the review, it was noted that GNA #34 was hired on 4/7/22; however, failed to reveal a performance evaluation had been completed for GNA #34 in the 2023 calendar year. On 6/26/25 at 10:02 AM the Human Resources Director (HRD #31) stated that everything was in the employees' files except for the online training from HealthStream and Relias. On 6/26/25 at 10:17 AM the surveyor shared the concern with HRD #31that there was no performance review for 2023 in GNA #34's employee file. She stated she knew she had some she had not filed by her desk because she did not want to misplace them. The surveyor and HRD #31 went to her office, and she looked through folders and file cabinets. On 6/26/25 at 10:23 AM HRD #31 stated for some reason she could not put her fingers on 2022, 2023, or 2024 performance reviews, but she could talk to the Director of Nursing (DON) who may have the performance reviews in her office. She confirmed she did not have a 2023 performance review for GNA #34. On 6/26/25 at 10:30 AM in an interview with the DON, the surveyor shared the above concerns, and they walked to her office together. The DON stated there was a binder with performance reviews and began flipping through pages but was unable to locate a 2023 performance review for GNA #34. Then, the DON stated, And you checked with HRD #31, and she said she did not have them? The surveyor shared HRD #31 stated said she did not have any performance reviews from 2022, 2023 or 2024. The DON stated she does not normally keep copies of performance reviews, but knew this binder was here from the previous DON. After flipping through more pages, the DON then stated if HRD #31 did not have them, she did not have them. Additionally, she stated she did not have binders with copies of 2023 or 2024 performance reviews and that she just had a binder from the previous DON with 2022 performance reviews, but had wanted to check and make sure it was not in another section of the 2022 binder. The surveyor shared this was a concern and the DON verbalized and confirmed understanding.

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	215147	A. Building B. Wing	06/27/2025

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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. Based on review of medical records and interviews with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists and agreed upon by the medical director in a timely manner. This was evident for 1 (Resident #87) out of 5 residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the residents' medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. Lorazepam, also known by the brand name Ativan, is a psychotropic medication and classified as a Schedule IV controlled substance. It is commonly used to treat anxiety disorders and is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression. The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at §483.45(c)(3), as any drug that affects brain activities associated with mental processes and behavior (CMS, 2023). These drugs include, but are not limited to, drugs in the following categories: antipsychotic, anti-depressant, anti-anxiety, and hypnotic medications. These medications can have serious potential risks, including side effects, drug interactions, and the possibility of neuroleptic malignant syndrome (a rare but potentially life-threatening condition) or tardive dyskinesia (a movement disorder that can develop if you take an antipsychotic medication) therefore requiring careful consideration and monitoring. The medical abbreviation PRN stands for 'pro re nata' (a Latin phrase), which means the medication is taken on an as needed basis and is not prescribed to be administered at scheduled times. On 6/20/25 at 7:39 AM the surveyor reviewed the medical record for Resident #87 which revealed on 12/27/24 and 1/22/24 the pharmacy MRRs noted to refer to a report for irregularities and/or recommendations. On 6/20/25 at 8:44 AM the surveyor requested copies of the two abovementioned medication regimen reviews and pharmacy recommendations for Resident #87 from the Director of Nursing (DON). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215147	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 6/20/25 at 8:28 AM when asked what happens during the monthly pharmacy MRR, she stated Pharmacist #40 comes in monthly and reviews all residents in the building. Then, she emails her recommendations to the DON, QA/IP (Quality Assurance/Infection Preventionist), Unit Manager (UM), and Clinical Care Coordinator (CCC). The DON further stated there was an individual form for each resident if Pharmacist #40 had a recommendation, and if there was no recommendation for a resident, there would be an evaluation in PCC (the facility's electronic medical record). After receiving the individual pharmacy recommendations, each unit prints them out and physically hands the individual recommendations to the physicians to review, document their response (by checking if they agree, disagree, or other with the Pharmacist), and then signing/dating the form. Then, the physicians give them back to the UM (1st floor unit) and CCC (2nd floor unit) who are responsible for putting in new orders and/or discontinuing orders, and who after doing so, faxes the completed/signed recommendations back to the Pharmacist, and the facility keeps a copy as well. On 6/20/25 at 10:24 AM the surveyor reviewed the 12/27/24 MRR and pharmacy recommendations which revealed the following recommendation from Pharmacist #40: Resident has an order for PRN Lorazepam concentrate. Please add a duration to this order. Hospice residents are not exempt from this regulation. Per CMS regulations, PRN or psychotropic drugs (a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior) are limited to 14 days. Antidepressants, antianxiety, sedative hypnotics, antihistamines, muscle relaxants. To extend the PRN order past 14 days the prescriber must: 1. Document their rationale in the medical record 2. Indicate the duration for the PRN order (example: 'for 30 days, for 60 days, etc.'). Further review of the documentation revealed the prescriber/physician had checked that they agreed with the Pharmacist's recommendation and signed/dated the form. On 6/20/25 at 10:31 AM the surveyor conducted a review of Resident #87's medical orders, which revealed an active order for Lorazepam Oral Concentrate 2 milligrams/milliliter *Controlled Drug*. Give 0.25 ml by mouth every 4 hours as needed for anxiety, agitation, and dyspnea with an order date of 4/18/25 and an end date of indefinite. On 6/20/25 at 11:25 AM the surveyor requested documentation where the provider, who agreed with the pharmacist's recommendation, documented their rationale in the medical record and indicated the duration for the PRN lorazepam order. On 6/20/25 at 12:21PM in an interview with the DON and the Regional Director of Operations (RDO #5) stated there was no documentation in the medical record for the PRN lorazepam, but she, the prescriber/physician, after surveyor intervention, added an addendum to the order today. When the surveyor asked for clarification, the DON stated, no, prior to today there was no documented rationale in the medical record of Resident #87. Furthermore, the RDO #5 verified and confirmed there was no duration on the PRN Lorazepam order.

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	215147	A. Building B. Wing	06/27/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents, review of the medical record, and interviews with facility staff, it was determined that the facility staff failed to ensure a resident received routine dental services in a timely manner. This was evident for 1 (#20) out of 47 residents reviewed during the facility's recertification survey. The findings include: On 6/16/25 at 9:25 AM in an interview with Resident #20 s/he stated s/he had bad teeth and needed to see the dentist. On 6/18/25 at 8:06 AM review of Resident #20's medical record revealed s/he was admitted to the facility on [DATE]. Further review of the medical record revealed 3 HealthDrive (facility's dental provider) notes from the Registered Dental Hygienist (RDH #37) dated 5/3/24, 11/5/24, and 5/7/25. The 5/3/24 dental note from RDH #37 stated, Periodic oral exam 10/16/24 and Annual exam 4/16/25; however, there was no documentation that the resident had been seen by a dentist for his/her periodic oral exam or annual exam. The 11/5/24 dental note from RDH #37 also stated, Periodic oral exam 10/16/24 and Annual exam 4/16/25; however, there was no documentation that the resident had been seen by a dentist for his/her periodic oral exam or annual exam. The 5/7/25 dental note from RDH #37 again stated, Periodic oral exam 10/16/24 and Annual exam 4/16/25; however, there was no documentation that the resident had been seen by a dentist for his/her periodic oral exam or annual exam. On 6/18/25 at 8:55 AM the surveyor requested the upcoming list of residents to be seen by the dentist. On 6/18/25 at 9:13 AM in an interview with the Director of Nursing (DON) when asked who completed dental exams for residents, she stated she would let the surveyor know. On 6/18/25 at 9:44 AM in an interview with the Medical Scheduler (MS #38) [for HealthDrive], the surveyor stated that in a HealthDrive note from RDH #37, the Recall section stated, Annual Exam. During the interview, the surveyor asked who performs the annual exams and MS #38 stated the dentist performs the annual exams and the hygienist performs the cleanings. Furthermore, MS #28 stated, Any exams need to be done by the dentist. On 6/18/25 at 10:04 AM review of Resident #20's care plan revealed a Problem: Impaired dentition r/t poor oral hygiene. Further review of the care plan revealed in the Approaches (to address the Problem) section: Consult with dentist and follow up with recommendations. On 6/18/25 at 11:09 AM in an interview with the DON she stated the dental exams are performed by the dentist. During the interview, the DON provided a list of residents scheduled to be seen by the dentist and Resident #20 was not on the list. On 6/18/25 at 11:10 AM the surveyor requested all dental notes from the dentist (not RDH) for Resident #20 and also specifically, the note(s) documenting his/her Annual Exam and Periodic Oral Exam. (continued on next page)

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	215147	A. Building B. Wing	06/27/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 2:01 PM the DON provided a dental note dated 4/16/24 from Dentist #39 for Resident #20's Initial Exam. It was observed and noted that Dentist #39 had documented in the Recommended Treatment section, Periodic Exam and Annual Exam; however, there was no further documentation provided that the resident had been seen by the dentist for his/her periodic exam or annual exam since being admitted to the facility. After surveyor intervention, the DON provided a new list of residents to be seen by the dentist and Resident #20's name was now observed on the list. On 6/20/25 at 10:11 AM in an interview with the DON and the Nursing Home Administrator (NHA), the surveyor shared the concerns that since the 5/3/24 dental note from RDH #37 and subsequently on 11/5/24 and 5/7/25, Resident #20 had not been seen by the dentist for his/her periodic oral exam and/or annual exam. During the interview in a dual observation with the DON and NHA of the 4/16/24 dental note, when asked if Resident #20 was seen by the dentist for either exam, the DON stated that the resident was seen yesterday. The surveyor shared that all dental and hygienist notes documented that Resident #20 was to have his/her exam around 10/16/24; however, s/he was not seen until 6/19/25 after surveyor intervention and asked if this was timely care. The DON stated no and verbalized and confirmed understanding of the concerns.

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	215147	A. Building B. Wing	06/27/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations of the facility's kitchen, review of kitchen records, and interview of staff, it was determined that the facility failed to prevent ice from building up in the walk-in freezer and in the refrigerator. This was evident for two refrigerators/freezers observed during the survey. The findings include: On 06/16/25 at 07:39 AM, Surveyor's initial observation of the cold storage/Freezer room in the kitchen, accompanied by the dietary staff, # 41 revealed that Ice was built on the floor and Ice particles were covering almost 75% of the freezer room Ceiling. Staff #41 was not aware of the preventive maintenance schedule for the freezer room. On 06/16/25 at 12:40 PM, the Surveyor observed the refrigerator/freezer in the second-floor nourishment room, to store residents' food, brought from outside. More than an inch of ice was built around the freezer. The surveyor also noted that the residents' snacks were placed in the refrigerator. On 06/25/25 at 11:45 AM, findings were reviewed with Dietary staff # 41 and with the Nursing home administrator. On 06/25/25 at 2:15 pm, the Nursing home administrator provided preventive maintenance schedules for the freezer room and for the refrigerators.

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	215147	A. Building B. Wing	06/27/2025

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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 complaints, reviews of a closed medical record and staff interview, it was determined that the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Residents #344, #340) of 15 complaints reviewed during the survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) A review of Resident #344's closed medical record on 06/24/25 at 1 PM revealed 2 physician certifications of incapacity. The first physician certification of incapacity was regarding Resident #344. It was dated and signed on 09/06/2022 at 12 PM by Resident #344's physician due to dementia. The second certificate of incapacity was regarding a totally different Resident. It was dated and signed on 09/08/2022 at 9:23 AM by a second facility physician which listed dementia as the reason for the incapacity certification. This was brought to the attention of the facility administrator on 06/25/25 at 3 PM. The administrator indicated that S/he was not aware of the error until the surveyor brought the error to his/her attention. 2) Review of complaint MD00214284 on 06/18/25 at 10 AM revealed an allegation that Resident #340's pain medication was not properly administered. A review of Resident #340's closed medical record on 06/18/25 revealed that Resident #340 was admitted to the facility on [DATE] after having surgery on his/her lower extremities. Resident #340's physician wrote orders for pain medication instructing the nursing staff to administer the pain medication as needed to Resident #340. A review of Resident #340's November 2024 medication administration records revealed that the nursing staff administered a dose of Dilaudid, 4 mg, orally, at 12:01 am, at 8:59 AM, and at 7:18 PM on 11/27/24. The surveyor then asked the facility director of nurses (DON) for a printout of any medication the nursing staff removed from the facility interim medication storage dispensing machine for Resident #340. The DON provided an interim medication dispensing print out that indicated Resident #340 was also administered a dose of Dilaudid 4 mg orally at 4:37 AM. A further review of Resident #340's closed medical record failed to reveal any nursing documentation that a nursing staff member administered a dose of Dilaudid 4 mg orally to Resident #340 at 4:37 AM on 11/27/24. In an interview with RN#36 on 06/25/25 at 12:18 PM, RN#36 stated that S/he reviewed Resident #340's closed medical record and stated that S/he recalled administering a dose of Dilaudid 4 mg orally to Resident #340 on 11/27/24 at 4:37 AM but admitted S/he forgot to document administering the pain medication in Resident #340's medical record.