STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215176	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Canton Harbor	1300 South Ellwood Avenue Baltimore, MD 21224

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 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** 18819 Based on complaint and reviews of a closed medical record, it was determined that the facility staff failed to follow a physician's order to administer an antibiotic for 3 days, a total of 6 doses. This was evident for 1 (Resident #6) of 11 residents reviewed during a complaint survey. The findings include: A review of complaint MD00213834 on 03/27/25 revealed an allegation Resident #6 was not receiving quality care and not being cared for properly. A review of Resident #6's closed medical record revealed that Resident #6 was admitted to the facility on [DATE] with diagnoses that included post-surgical orthopedic procedure due to a fractured right ankle and cystitis with pyuria. A review of Resident #6's closed medical record on 03/27/25 at 12 PM revealed a physician order dated 01/18/25 at 9 AM instructing the nursing staff to administer the antibiotic, Cefpodoxime Proextill, 100 mg, orally, every 12 hours for cystitis for 3 days. A review of Resident #6's January 2025 Medication Administration Record (MAR) revealed Resident #6 did not receive a dose of the antibiotic on 01/18/25. A review of Resident #6's nursing progress notes, dated 01/18/25 at 2:11 PM revealed a nursing progress note indicating that the charge nurse had contacted the facility pharmacy and requested the pharmacy to send Resident #6's antibiotic stat. Further review revealed that Resident #6 only received 2 doses of the antibiotic on 01/19/25 and 01/20/25 (4 doses). The nursing staff failed to administer a total of 6 doses of the antibiotic Cefpodoxime Proextill to Resident #6 every 12 hours over 3 days for a total of 6 doses. The facility administrator and corporate nurse were made aware of the finding during the exit conference on 04/01/25 at 1:30 PM.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, reviews of a closed medical record, reviews of the resident's electronic medical records, and interviews with facility staff members, it was determined that the facility staff failed to 1) update a resident's skin and wound care plan after being readmitted with actual stage II wounds, 2) document a resident's assessment timely demonstrating the healing or deterioration of a resident's Stage II wounds, and notifying the resident's physician and family of the resident's stage II wounds. This was evident in 1 (Resident #2) of 11 residents reviewed during a complaint survey. The findings include. A pressure ulcer also known as pressure sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full-thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). A review of complaint MD00204530 on 03/20/25 revealed an allegation Resident #2 was not being provided incontinence care timely. A review of Resident #2's closed medical record revealed that Resident #2 was originally admitted to the facility on [DATE]. Resident #2 then went to the hospital on 04/07/24 and then readmitted to the facility on [DATE] for the reinsertion of a feeding tube. Resident #2 is totally dependent upon the facility staff for all of her care and needs. Further review of Resident #2's closed medical revealed a readmission skin assessment that was documented as being performed on 04/09/24 at 1:36 AM. At this time, Resident #2 was identified with 4 - stage II wounds. They included: Site #1 - a new Left Gluteal Fold, Pressure Injury, Stage II, that measured 1 cm x 0.4 cm, 25-50% epithelial skin present, with redness observed. Site #2 - a new Left Gluteal Fold, Pressure Injury, Stage II, that measured 1 cm x 0.5 cm, 51-75% epithelial skin present. Site #3 - a new Left Inner Buttock, Pressure Injury, Stage II, that measured 1 cm x 2 cm, 51-75% epithelial skin present, with Wound edges that are Undefined/Irregular, and redness was observed. Site #4 - a new Right Inner Buttock, Pressure Injury, Stage II, that measured 2 cm x 2 cm, 51-75% epithelial skin present, with Wound edges that are Undefined/Irregular, and redness was observed. Greer's goo ointment was indicated as treatments for the wounds. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the 04/09/24 readmission skin assessment that identified the 4 different - Stage II wounds on Resident #2 skin, the staff failed to document on a skin record if the 4 different wounds healed or deteriorated before being sent to the hospital on 04/28/24. Between 04/09/24 and 04/25/24, Resident #2's physician failed to document a skin assessment on the following assessment dates: 04/09/24, 04/11/24, 04/12/24, 04/15/24, 04/16/24, 04/18/24, 04/19/24, 04/23/24, and 04/24/24. On 04/26/24 at 11:08 AM the Nurse Practitioner documented Resident #2 was being treated with Greer's [NAME] for sacral excoriation. Resident #2 was sent to the hospital on 04/28/24 after a fall and did not return to the facility. A review of Resident #2's care plans on 03/20/25 revealed an impaired skin integrity prevention care plan related to Resident #2's fragile skin and decreased mobility. This care plan was initiated on 03/22/24. The goal was to maintain Resident #2's intact skin through the review period. Nursing approaches included: to remind/assist resident to turn/reposition at least every 2 hours, apply arm/leg protectors per order, apply air mattress per order, apply barrier cream after each incontinent episode, apply a brief as needed, apply a pressure reducing cushion to chair, apply a pressure relieving mattress to bed, to avoid scrubbing and pat dry sensitive skin, clean peri-area after each incontinent episode, then apply barrier cream. After Resident #2 was readmitted to the facility on [DATE] and identified with 4 new areas of skin breakdown (4 - stage II wounds), the facility staff failed to update Resident #2's impaired skin integrity prevention care plan to an actual impairment skin integrity and update the nursing interventions on 04/09/24. On 04/29/24, the facility wound nurse did update Resident #2's skin/wound prevention care plan. The skin/wound prevention care plan goal was to heal Resident #2's right inner buttocks, Gluteal crease moisture associated skin damage. On 04/29/24, Nursing approaches were updated included: monitor Resident #2's wounds for effectiveness, assist resident to turn/reposition at least every 2 hours, a nurse to perform weekly assessments, document and notify providers of changes, observe for changes and report changes to the nurse, and to provide education to resident/family/caregivers related to impaired skin integrity and plan of care. Resident #2 was sent to the hospital on 04/28/24 and did not return to the facility. The nursing staff were unable to implement these new interventions since the care plan had not been updated until 04/29/24 after Resident #2 was discharged from the facility on 04/28/24. Review of Resident #2's 04/08/24 readmission care plan summary that was created on 04/09/24 at 2:21 AM, revealed a nursing skin condition that indicated Resident #2 was readmitted with a pressure injury. Resident #2's family was not presented with the readmission care plan summary until 04/22/24 via a telephone call. In an interview with the facility wound nurse and the Director of Nurses on 03/20/25 at 11:44 AM, the facility wound nurse stated that the facility does have a Wound Care Physician that assesses residents weekly but does not see Residents Identified with Stage I or II wounds unless she asks for a consultation. The wound nurse stated that she documents resident skin/wound assessments on paper and then at a later time she will document the resident skin/wound assessments in the resident's electronic medical record. The wound nurse stated it takes time to place my skin/wound assessments into the computer. The nurse surveyor indicated that he was unable to locate any wound assessments regarding Resident #2 wounds after being readmitted on [DATE]. The nurse surveyor requested the wound nurse to locate any hand written/paper assessments that she may have regarding Resident #2's wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Regional Nurse Consultant on 03/21/25 at 12:25 PM, the Regional Nurse Consultant stated that the wound nurse could not located any hand written paper/written skin/wound assessments for Resident #2. The Regional Nurse Consultant also stated that the wound nurse did document in the electronic medical record that on 04/11/24 Resident #2's 4 - stage II wounds, identified on 04/08/24, were moisture associated skin damage (MASD). The 04/11/24 wound assessments were entered into Resident #2's electronic medical record on 04/29/24 as late entries after the Resident had been discharged from the facility.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 18819 Based on complaints, reviews of active and closed medical records, reviews of the residents' electronic medical records, and interviews with staff members, it was determined that the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident in 3 (Resident #2, #6, #10) of 11 residents reviewed during a complaint 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 complaint MD00204530 on [DATE] revealed an allegation Resident #2 was not being provided incontinence care timely. A review of Resident #2's closed medical record revealed that Resident #2 was originally admitted to the facility on [DATE] and then readmitted to the facility on [DATE] due to being sent to the hospital for the reinsertion of a feeding tube. Resident #2 is totally dependent upon the facility staff for all of her care and needs. Further review of Resident #2's closed medical revealed a readmission skin assessment that was documented as being performed on [DATE] at 1:36 AM. At this time, Resident #2 was identified with 4 - stage II wounds. They included: Site #1 - a new Left Gluteal Fold, Pressure Injury, Stage II, that measured 1 cm x 0.4 cm, ,d+[DATE]% epithelial skin present, with redness observed. Site #2 - a new Left Gluteal Fold, Pressure Injury, Stage II, that measured 1 cm x 0.5 cm, ,d+[DATE]% epithelial skin present. Site #3 - a new Left Inner Buttock, Pressure Injury, Stage II, that measured 1 cm x 2 cm, ,d+[DATE]% epithelial skin present, with Wound edges that are Undefined/Irregular, and redness was observed. Site #4 - a new Right Inner Buttock, Pressure Injury, Stage II, that measured 2 cm x 2 cm, ,d+[DATE]% epithelial skin present, with Wound edges that are Undefined/Irregular, and redness was observed. Greer's goo ointment was indicated as treatments for the wounds. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After the [DATE] readmission skin assessment that identified the 4 different - Stage II wounds on Resident #2 skin, the staff failed to document on a skin record if the 4 different wounds healed or deteriorated before being sent to the hospital on [DATE]. Between [DATE] and [DATE], Resident #2's physician failed to document a skin assessment on the following assessment dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 11:08 AM the Nurse Practitioner documented Resident #2 was being treated with Greer's [NAME] for sacral excoriation. Resident #2 was sent to the hospital on [DATE] after a fall and did not return to the facility. A review of Resident #2's care plans on [DATE] revealed an impaired skin integrity prevention care plan related to Resident #2's fragile skin and decreased mobility. This care plan was initiated on [DATE]. The goal was to maintain Resident #2's intact skin through the review period. Nursing approaches included: to remind/assist resident to turn/reposition at least every 2 hours, apply arm/leg protectors per order, apply air mattress per order, apply barrier cream after each incontinent episode, apply a brief as needed, apply a pressure reducing cushion to chair, apply a pressure relieving mattress to bed, to avoid scrubbing and pat dry sensitive skin, clean peri-area after each incontinent episode, then apply barrier cream. After Resident #2 was readmitted to the facility on [DATE] and identified with 4 new areas of skin breakdown (4 - stage II wounds), the facility staff failed to update Resident #2's impaired skin integrity prevention care plan to an actual impairment skin integrity and update the nursing interventions on [DATE]. On [DATE], the facility wound nurse did update Resident #2's skin/wound prevention care plan. The skin/wound prevention care plan goal was to heal Resident #2's right inner buttocks, Gluteal crease moisture associated skin damage. On [DATE], Nursing approaches were updated included: monitor Resident #2's wounds for effectiveness, assist resident to turn/reposition at least every 2 hours, a nurse to perform weekly assessments, document and notify providers of changes, observe for changes and report changes to the nurse, and to provide education to resident/family/caregivers related to impaired skin integrity and plan of care. Resident #2 was sent to the hospital on [DATE] and did not return to the facility. Review of Resident #2's [DATE] readmission care plan summary that was created on [DATE] at 2:21 AM, revealed a nursing skin condition that indicated Resident #2 was readmitted with a pressure injury. Resident #2's family was not presented with the readmission care plan summary until [DATE] via a telephone call. In an interview with the facility wound nurse and the Director of Nurses on [DATE] at 11:44 AM, the facility wound nurse stated that the facility does have a Wound Care Physician that assesses residents weekly but does not see Residents Identified with Stage I or II wounds unless she asks for a consultation. The wound nurse stated that she documents resident skin/wound assessments on paper and then at a later time she will document the resident skin/wound assessments in the resident's electronic medical record. The wound nurse stated it takes time to place my skin/wound assessments into the computer. The nurse surveyor indicated that he was unable to locate any wound assessments regarding Resident #2 wounds after being readmitted on [DATE]. The nurse surveyor requested the wound nurse to locate any written/paper assessments that she may have regarding Resident #2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Regional Nurse Consultant on [DATE] at 12:25 PM, the Regional Nurse Consultant stated that the wound nurse could not locate any paper/written skin/wound assessments for Resident #2. The Regional Nurse Consultant also stated that the wound nurse did document in the electronic medical record that on [DATE] Resident #2's 4 - stage II wounds identified on [DATE] were moisture associated skin damage (MASD). These [DATE] wound nurse assessments were entered into Resident #2's electronic medical record on [DATE] as late entries after the Resident had been discharged from the facility. 2) A review of complaint MD00213834 on [DATE] revealed an allegation Resident #6 was not receiving quality care and being not cared for properly. A review of Resident #6's closed medical record revealed that Resident #6 was admitted to the facility on [DATE] with diagnoses that included a post-surgical orthopedic procedure due to a fractured right ankle and cystitis with pyuria. A review of Resident #6's closed medical record on [DATE] 12 PM revealed a physician order dated [DATE] at 11 PM instructing the nursing staff to apply a pressure relieving mattress to the bed every shift for skin protection and offloading. A review of Resident #6's [DATE] Treatment Administration Record (TAR) revealed that the nursing staff signed off, every shift, that a specialty mattress had been applied to Resident #6's bed starting on [DATE]. In an interview with the facility Central Supply Director (Staff Member #27) on [DATE] at 2:45 PM, The Central Supply Director stated that she does not have a supply of specialty mattresses in the facility and that a specialty mattress has to be ordered by the nursing staff through our vendor. In an interview with the facility Corporate Nurse, [DATE] at 2:45 PM, the facility Corporate Nurse stated that the facility admissions director or the nursing unit manager will order specialty mattresses for the residents. The facility Corporate Nurse presented the nurse surveyor with a mattress order receipt that indicated the facility received a specialty mattress for Resident #6 on [DATE]. The Corporate Nurse confirmed that the nursing staff were signing off the use of a specialty mattress for Resident #6's bed since [DATE] but the mattress had not been delivered and applied to Resident #6's bed until [DATE]. 3) A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. Instructions for completing a Maryland MOLST include: A Physician, Nurse Practitioner (NP), or a Physician Assistant (PA) must accurately and legibly complete the form and then sign and date it. This also includes correctly identifying the name of the resident at the top of the form. Voiding the Form: to void this medical order form, a physician or nurse practitioner shall draw a line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST form. Keep the voided order form in the patient's active or archived medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In Maryland Law: Surrogates and Life-Sustaining Treatment: A surrogate may consent to the withholding or withdrawal of life-sustaining procedures if the patient's attending physician and a consulting physician certify, to a reasonable degree of medical certainty, that the patient has a terminal or end-stage condition or is in a persistent vegetative state. A surrogate may not consider a patient's pre-existing, long-term mental or physical disability in making a decision to withhold or withdraw life-sustaining procedures. A surrogate who is a guardian usually must obtain the court's permission to authorize the withholding or withdrawal of life-sustaining procedures. Review of complaint MD00210555 on [DATE] revealed an allegation Resident #10 was not receiving quality care while residing in the facility. A review of Resident #10's medical record on [DATE] at 12:56 PM revealed 2 current MOLST forms in Resident #10 paper medical record. The first MOLST form was dated [DATE] and indicated Resident #10 did not want: CPR, option a - 2, to be placed on a ventilator, did not want blood products, did not want artificial nutrition and hydration, and did not want dialysis. The second MOLST form found in Resident #10's medical record was dated [DATE] and indicated that Resident #10 wanted to be a Full Code. The back page of the [DATE] MOLST form had not been completed. The two active incongruent MOLST forms could be confusing to staff if an emergency situation arose regarding Resident #10. The facility corporate Registered Nurse (RN) was immediately made aware of the situation, she contacted Resident #10's attending physician who was in the facility. Resident #10's physician voided the [DATE] MOLST form.