STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215186	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Chesapeake	305 College Parkway Arnold, MD 21012

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and staff interview it was determined that the facility failed to ensure that all allegations of abuse were reported to the state agency (SA) within the required reporting timeframe. This was evident for 3 (#100, #69, and #2) of 5 residents reviewed for abuse. The findings include: 1) Review on 9/18/24 at 12:06 PM of the facility's investigation filed for the facility reported incident #MD00198616 revealed Resident #100 reported an allegation of abuse to facility staff. According to the statement written by the Social Worker the report of abuse was made on 10/6/23 at 12:15 PM. On 9/19/24 at 9:41 AM a review of the facility email confirmation, sent by the Director of Nursing (DON), revealed that the report had not been sent to the SA until 10/6/23 at 3:14 PM, which was beyond the 2-hour timeframe. An interview with the DON on 9/19/24 at 12:14 PM revealed that the facility had not developed a process to ensure timely submission of allegations of abuse related to the information requested on the facility report form and the approval from the corporate level before sending the report. The NHA was made aware of the concerns at 12:30 PM and confirmed what the DON had reported. 48393 2) A review of a facility reported incident, MD00199051, revealed Resident #69 had an x-ray ordered and completed in the facility on 10/25/23 at 2:09 PM with results that indicated an acute fracture of the right proximal humerus. The resident was transferred to the emergency room (ER) on 10/25/23, when the fracture was identified. The resident returned to the facility on [DATE] at 2:35 AM in a right arm sling along with confirmation of a right proximal humerus fracture. The resident also had an order to follow up with orthopedics. Further review of the facility investigation revealed that the initial report was not submitted to OHCQ (Office of Health Care Quality) until 10/31/23 at 4:45 PM although the injury was identified on 10/25/23. The facility is to report all allegations of abuse, including injuries of unknown source, that resulted in serious bodily injury within 2 hours of the incident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director Of Nursing (DON) on 09/19/2024 at 9:42 AM, it was revealed that the injury was initially thought to be the result of a previous fall. The DON further stated the team began the investigation of the fall with fracture on 10/25/23. After in-depth chart review, staff interviews, and case review by the Medical Director was completed, the team decided that the injury was possibly an injury of unknown origin. The DON further stated that the injury of unknown origin was initially reported to OHCQ on 10/31/2023. An interview with the Administrator on 09/19/24 at 02:01 PM confirmed that the injury of unknown origin was not reported to OHCQ until 10/31/23 because the team initially thought the injury was the result of a previous fall. 14894 3) A review of a facility reported incident, MD00183710, revealed Resident #2 had a fall on 9/9/22 which was 12 days prior to the date of the incident. The Resident was in an electric wheelchair out front of the building. The resident was moving in the wheelchair and went off of the curb. As a result, the resident hit their head on the concrete. The resident maintained good head alignment and 911 was called. Resident did not lose consciousness. The resident had no change in vision or bleeding. Resident stated they misjudged where the curb was while backing up. The resident returned from the hospital on 9/11/22 at 7:43 PM. Further review of the clinical record failed to find evidence that the state agency had been notified. The Administrator was interviewed on 9/20/24 at 9:51 AM. She was informed of the fall and asked if she reported it. She recounted the incident and acknowledged the fall with injury. Confirmed that it was not reported the Maryland Office of Healthcare Quality.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on record review and interview it was determined that the facility failed to ensure a Resident's care plan was revised in a timely manner. This was found to be evident for 1 (Resident # 113) out of 1 Resident reviewed for care plan revisions. The findings include: During a review of Resident #113's medical records conducted on 09/16/24 at 9:51 AM, it was discovered that the resident fell on [DATE], 07/28/23 & 07/31/23. A care plan is a document that outlines the actions and interventions needed to address a person's health or care needs. It can include information about a patient's health conditions, medications, and healthcare providers. Care plans can help ensure that patients receive consistent care. A review of Resident #113's care plan conducted on 09/16/24 at 10:00 AM, revealed the care plan for falls had not been revised to include the resident's falls on 07/14/23, 07/28/23 & 07/31/23. During an interview conducted on 09/16/24 at 12:19 PM, the Regional Clinical Services Manager stated that after she reviewed Resident #113's care plan she determined that the care plan had not been updated to include the falls for 07/14/23, 07/28/23, & 07/31/23.

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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** 42783 Based on interviews and record reviews it was determined that the facility failed to ensure a resident's safety. This was found to be evident for 1 (Resident #36) out of 1 resident's reviewed for quality of care during the re-certification survey. The findings include: During an interview conducted on 09/11/24 at 10:33 AM, Resident #36 stated that on 09/07/24 Geriatric Nursing Assistant (GNA) #8 attempted to assist the resident in the transfer from the bed to the electric wheelchair. The resident stated that the GNA assisted him/her from a lying position to a sitting position to the side of the bed. The resident stated that he/she advised the GNA that the back of his/her legs were not flush against the mattress which was required for a safe transfer from the bed to the wheelchair when using the transfer board. The resident further stated that the GNA went behind the bed from where the resident sat and attempted to pull the resident by his/her pants closer to the mattress. As a result, the resident slid off the bed and onto the floor. According to Centers of Medicare and Medicaid Services (CMS) the Minimum Data Set (MDS) is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes (NHs). On 09/11/24 at 11:02 AM a review of Resident #36's MDS mobility assessment dated [DATE] revealed the resident required partial/moderate assistance for lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. On 09/14/24 at 6:19 AM a review of a written statement from GNA #8 stated that I went behind [resident's pronoun] and I was holding the back of his pant to prevent [resident's pronoun] from sliding; [resident's pronoun] also said [resident's pronoun] feel like [resident's pronoun] is sliding down. During an interview conducted on 09/14/24 at 7:30 AM, the Rehabilitation Director #14 stated that Resident #36 required 1 person to assist when using the transfer board. The Rehabilitation Director stated that GNA #8 should not have gone behind the resident to pull the resident closer to the mattress. The expectation for a proper transfer is to stand in front of the resident to perform a safe proper transfer. The Rehabilitation Director further stated that GNA #8 would be provided training on safe and proper transfer of a resident by the therapy department.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations, interviews and record reviews it was determined that the facility failed to ensure that medications were secured and stored safely. This was found to be evident for 5 out of 7 observations for medication storage during the recertification survey. The findings include: Insulin is a hormone that helps regulate blood sugar levels by moving glucose from the bloodstream into cells for energy. Insulin therapy often is an important part of diabetes treatment. It helps keep blood sugar under control and prevents diabetes complications. It works like the hormone insulin that the body usually makes. 1) During a medication observation conducted on 09/05/24 at 8:00 AM, this Surveyor inspected Registered Nurse (RN) #4's medication cart. The Surveyor discovered an unopened Lispro Kwikpen 100/u/ml insulin pen for Resident #63. The insulin pen was dated 08/30/24 and stored in a plastic bag that had a pharmacy label on it that said refrigerate until open. Following the observation, an interview was conducted with RN #4 who confirmed the insulin pen had not been opened. The RN stated that the facility's expectation is that the pharmacy instructions were to be followed, and the insulin pen should have been refrigerated until opened. The RN further stated that the insulin pen would be discarded and reordered. During a review of Resident's Medication Administration Record (MAR) conducted on 09/05/24 at 9:17 AM it was revealed that Resident #63 had an order for HumaLOG KwikPen Solution Pen-injector 100 Unit/ML (millimeter) (Insulin Lispro) inject as per sliding scale. 2) During a medication observation conducted on 09/06/24 at 8:22 AM, this Surveyor inspected Licensed Practical Nurse (LPN) #22's medication cart. The Surveyor discovered an unopened Lispro Kwikpen 100/u/ml insulin pen for Resident #60. The insulin pen was dated 08/30/24 and stored in a plastic bag that had a pharmacy label on it that said refrigerate until open. 3) A continued inspection of LPN #22's medication cart revealed multiple loose pills in the bottom of the second drawer: 3 loose pink tablets, 2 loose white tablets, 1/2 pink tablet, 1 orange and blue capsule. Following the observations, an interview was conducted with LPN #22 who confirmed that the insulin pen that was stored in a plastic bag had not been opened. She confirmed that the plastic bag had a pharmacy label that stated refrigerate until open. The LPN further stated that she would speak with her Unit Manager to receive directions on disposing of the insulin pen and loose tablets and reordering the insulin pen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident's Medication Administration Record (MAR) conducted on 09/06/24 at 9:49 AM it was revealed that Resident #60 had an order for Insulin Lispro Solution (Insulin Lispro) Inject as per sliding scale. 49815 4) During the initial tour of Nursing Unit 3 at 11:45 AM on 9/3/2024 the surveyor observed Resident #46 lying down in bed. On the overbed table in Resident #46's room was a medication cup with one pink tablet in the medication cup at the resident's bedside. The surveyor interviewed the Assistant Director of Nursing/IP (ADON/IP) on 9/3/24 at 11:49 AM who was walking by Resident #46's room at the time of the surveyor observation of the medication at Resident #46's bedside. The surveyor asked the ADON/IP what the expectation was for medications at the resident's bedside and the ADON/IP stated that medication should not be left at the resident's bedside. The ADON/IP removed the medication cup with the one pink tablet from Resident #46's overbed table and indicated that he would investigate the medication. The ADON/IP returned to the surveyor and stated that the pink tablet was PreserVision and that this was confirmed with Resident #46's nurse. On 9/12/2024 at 9:30 AM the surveyor reviewed Resident #46's medical record specifically the physician orders for the month of September 2024. According to the physician orders for Resident #46, there is a medication order for PreserVision AREDS 2 Oral Tablet Chewable (Multiple Vitamin w/Minerals). Give 1 tablet by mouth one time a day for macular degeneration. 14894 5) This surveyor was touring the facility on 9/3/24 when an unlocked medication cart was observed at 11:10 AM. The medication cart was located next to room [ROOM NUMBER]. One staff member was observed walking past the cart at 11:13 AM and then a second staff member wearing a white lab coat with a stethoscope around her neck walked past the cart. A resident wheeled past it in their wheelchair at 11:17 AM followed by a staff member wearing black scrubs. A nurse, staff #26, walked past the cart at 11:19 AM while pushing a medication cart of her own and used her left hip to lock the cart. She was interviewed and confirmed it was unlocked. The Director of Nursing was interviewed on 9/4/24 at 11:53 AM. He was informed of the findings, and he said he would investigate.

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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. 49815 Based on observation, interviews and medical record review it was determined that the facility failed to follow appropriate infection prevention and control practices. This was found to be evident during the annual recertification survey. The findings include: During the initial tour of the laundry department on 9/9/2024 at 8:25 AM with the Housekeeping Floor Technician (#12) the surveyor observed an employee's personal backpack on the floor underneath the clean laundry folding table in the clean linen area of the laundry room. The surveyor conducted an interview on 9/9/2024 at 8:45 AM with the Housekeeping Floor Technician (#12) and the Laundry Aide (#13) who acknowledged that the employee's personal backpack was on the floor and that the expectation was that employee's personal items were not to be stored in the laundry room. Enhanced Barrier Precautions (EBP) are a set of infection control measures that aim to reduce the spread of multidrug-resistant organisms. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. At 9:50 AM on 9/9/2024 the surveyor conducted infection control rounds on Nursing Unit 1. During the tour, the surveyor observed Resident (#81) and Resident (#89) rooms without an Enhanced Barrier Precautions (EBP) signage posted on the outside of the resident's room door. Enteral tube and feedings are a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation. The state of being fed by a feeding tube is called gavage, enteral feeding or tube feeding. Foley catheter is a thin, flexible tube that drains urine from the bladder into a collection bag. It is a type of indwelling urinary catheter which means it is inserted into the body and left in place. The surveyor at 10:30 AM on 9/9/2024 reviewed the medical records of Residents (#81 and #89). Resident (#81) has physician orders for enteral tube care and feedings, Foley catheter care and Enhanced Barrier Precautions (EBP), and does not have an Enhanced Barrier Precautions (EBP) signage on the outside of the resident's room door. Resident (#89) has physician orders for wound care and Enhanced Barrier Precautions (EBP) and does not have an Enhanced Barrier Precautions (EBP) signage on the outside of the resident's room door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:00 AM on 9/9/2024 the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding the policy and procedure for Enhanced Barrier Precautions (EBP). During this interview the ADON/IP stated that all residents with catheters, enteral feedings, wounds, central venous catheters, intravenous lines and tracheostomies should have an Enhanced Barrier Precautions (EBP) signage posted on the resident's room door and have a physician order for Enhanced Barrier Precautions (EBP). The surveyor toured Nursing Unit 1 with the ADON/IP at 11:10 AM on 9/9/2024. The ADON/IP and the surveyor observed that there was not signage posted on the resident's room doors for Residents (#81 and #89) for Enhanced Barrier Precautions (EBP). The ADON/IP stated that he would look into this. At 11:38 AM on 9/9/2024 the ADON/IP and the Regional Clinical Services Manager (RCSM) confirmed on observation with the surveyor that the Enhanced Barrier Precautions (EBP) signage was not posted on the room doors in the appropriate place for Residents (#81 and #89) and that Residents (#81 and #89) have physician orders for Enhanced Barrier Precautions (EBP). On 9/11/2024 at 11:08 AM the surveyor conducted an infection control tour of Nursing Unit 3. The surveyor observed Registered Nurse (#10) who was leaning over the counter eating her lunch in the clean utility room on Nursing Unit 3. In addition, this was observed by the Licensed Practical Nurse (#11) who stated to the Registered Nurse (#10) that she was not to be eating in the clean utility room. The surveyor interviewed the Nursing Unit 3 Unit Manager (#9) and asked her what the expectation was for the nursing staff eating in the clean utility room at 11:15 AM on 9/11/2024. The Unit Manager (#9) stated that nursing staff should not be eating in the clean utility room and that staff should be eating in the employee break room.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49815 Based on observation, staff interview and facility record review it was determined that facility failed to maintain an effective pest control program. This was evident in the facility kitchen and in the facility conference room. The findings include: On the initial tour of the facility's kitchen on 9/3/24 at 8:57 AM with the Certified Food Service Manager (CFSM) the surveyor observed a fly that was flying around near the top shelf of the food storage rack in the dry storage room located in the kitchen. The surveyor interviewed the Certified Food Services Manager (CFSM) at 9:15 AM on 9/3/24 during the kitchen tour, and the CFSM acknowledged that there was a fly that was observed flying around near the top shelf of the food storage rack in the dry storage room. The Certified Food Services Manager (CFSM) stated to the surveyor that the Pest Control Company is scheduled for service and treatment every other week for the facility. At 7:20 AM on 9/18/24 the surveyors observed gnats flying around in the conference room. Additionally, the Nursing Home Administrator (NHA) was observed by the surveyor swatting at a gnat in the conference room when the NHA delivered requested documents to the surveyors. The surveyors received the ORKIN Pest Control Service Reports from the Nursing Home Administrator on 9/12/24 at 9:10 AM. The surveyor reviewed the ORKIIN Pest Control Service Reports from March 2024 through August of 2024. The findings on these reports included the following dates and comments about service: 8/7/2024 - Inspected and treated throughout kitchen area storage area a few units with ants check log for notes check office areas added fly to kitchen due to fly issues; 7/25/2024 - Inspected and treated throughout kitchen area, storage area, break room area, fruit fly issue, and kitchen treated drains unit with ants and with spiders, check logbook for notes; 7/15/24 - Inspected and treated throughout checked all logbook. Treated rooms with ant issues throughout also kitchen has sanitation issues with drains fruit flies underneath sink areas trash cans need to be dumped, and clean drains need to be cleaned; 6/20/2024 - just flying ants around door just treated exterior last week. Told give it time to work, OK with it; 6/13/2024 - Inspected and treated throughout facility checked all logbook monitors no live pest issues to support a couple of Beatles and a few of the monitors and office areas changed out monitors and treated throughout. Wants to get exterior service. Will be there tomorrow morning to treat exterior; 5/31/2024 - Inspected and treated throughout office area break area no live pest issues to report few units with issues. No live and spotted on the interior. Still treated throughout; 4/12/2024 - Inspected and treated throughout kitchen area storage area, brake room area no live pest issues to report roach citing near vending machines put monitors out and treated around vending machines; 3/28/2024 - Inspected and treated throughout entire building checked all logbook only unit for treatment for ants Unit 211 no other issues to report in kitchen area, storage area or office areas; 3/20/2024 - Inspected and treated throughout kitchen area storage area break room area no live test issues to report sanitation issues in the kitchen areas check logbook for residence one unit with roaches 213 treated all around.