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	02/04/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on administrative reviews and interviews it was determined the facility failed to ensure that nursing staff members complete skills-based competency training annually. This was evident for 1 of 4 GNAs personnel files reviewed (GNA #15) and 1 out of 1 RN (RN #13) during the investigation phase of a recertification survey. The findings include:On 02/04/2026 at 10:00 AM the surveyor initiated the employee record review of nursing personnel which revealed: GNA #15 was hired on 01/28/2014. Additionally, the employee's personnel file did provide evidence of annual clinical skills competency training documentation between 2015 and 2024.RN #13 did not have annual clinical skills training documentation present in the employee file for years 2023 and 2024. RN #13 was hired on 06/22/2022.On 02/04/2025 at 10:25 AM the surveyor was provided with a copy of performance evaluation policy by the facility. The policy stated: Each employee will have an annual performance evaluation that reviews performance based on expectation identified in the job description. The immediate supervisor is responsible for completion of the evaluation, which becomes a part of the individuals permanent record. The facility did not provide the surveyor with a copy of the policy related to annual clinical training for licensed RN, LPN, or GNA staff prior to the exit conference.On 02/04/2025 at 12:00 noon the surveyor interviewed the DON and the HR manager who confirmed the results of the findings of the personnel files of the employees. Also, the DON and HR manager stated that the facility was unable to provide proof of skills competency evaluations for the staff listed above. The results of the surveyor's review of the facility personnel files were discussed during the exit conference on 02/04/2026.

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 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 Geriatric Nursing Assistants' (GNAs)personnel files and staff interviews it was determined that the facility failed to ensure that annual performance evaluations were completed at least every twelve months. This was evident for 2 (GNA #15, GNA #9) out of 4 GNA personnel files reviewed during a recertification survey.The findings include: The annual performance evaluation identifies what clinical competency skills the geriatric employee should improve or maintain based on the annual 12-hour competency skills training required for geriatric nursing assistants.A review of the personnel files of four GNA employees was conducted between 10:00 AM and 12 noon on 02/04/2026. GNA #15's personnel record revealed there were no annual performance evaluations found between the years of 2016 through 2026. GNA #15 was hired on 01/28/2014 per the facility personnel file. GNA #9 did not have an annual performance evaluation present for years 2024 or 2025 and was hired on 07/26/2023. At 12 noon on 02/04/2026 the surveyor reviewed the personnel file findings with the Director of Nursing and the Human Resources Manager. The human resources manager confirmed the facility could not provide evidence of the annual performance evaluations being performed during the time periods listed above.This deficient practice was reviewed during the exit conference on 02/04/2026.

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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 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 observation, interview, and record review, it was determined that the facility failed to maintain the food service area in a sanitary manner and failed to properly store and label food items. This deficient practice was evident for the kitchen area observed during the recertification survey.The findings include: 1. On 01/29/26 at 7:28 AM, during observation of the main kitchen, the following sanitary concerns were identified:A box containing cans of ginger ale and tomato juice was stored directly on the floor in close proximity to the hand sink floor drain.A spice rack contained an open container of dill weed, approximately two-thirds full, which was undated.Debris was observed in the floor drain located beneath the dishwasher.A pair of used plastic foodservice gloves was observed on the floor near the dishwasher.Multiple broken floor tiles were noted near the dishwasher, with standing gray water present within the crevices.Brown, dried stains were observed on the wall adjacent to the handwashing sink. 2. At 7:31 AM, observation of a freestanding refrigerator unit located in the kitchen revealed:Two hard-boiled eggs and two muffins wrapped together in plastic wrap with no labels or dates.Two containers of applesauce marked with a preparation date of 01/24 and a use-by date of 01/27, which were expired at the time of observation. 3. Observation of the dry storage area revealed:A broken floor tile partially covering the area from which it was missing.A box of condiments stored on a shelf without any date indicating when the items were received into the facility, while other items in the area were appropriately marked with received dates.On 02/02/26 at 12:48 PM, an interview was conducted with Staff #14 regarding the observed concerns related to missing dates on food items, expired and unlabeled food, debris in floor drains, used gloves on the floor, and the broken tiles, some of which were collecting standing water. At that time, the brown stains on the wall adjacent to the hand sink had been cleaned and the used gloves were no longer present on the floor. A walkthrough of the kitchen revealed debris was still present in the floor drain. Staff #14 stated these concerns would be addressed right away.During the same interview, Staff #14 acknowledged the broken floor tiles and standing water as a concern and stated there were plans to renovate the kitchen and replace the flooring.

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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. Based on medical record review and interviews, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices that accurately documented the resident current medical diagnosis. This was evident for 1 (resident #3) out of 9 residents reviewed during the recertification survey.The findings include: Review of resident #3 medical record on 02/03/2026 at 09:19 AM revealed a Care Plan Problem dated 12/15/2025 stating that the resident has potential safety risk r/t seizure disorder as evidenced by medication management, a current medication order dated 12/02/2025 for Lamotrigine Oral Tablet 200mg give 1 tablet by mouth one time a day for Seizure and a psychiatric note dated 01/29/2026 stating resident is taking medication Lamotrigine for a diagnosis of Bipolar Disorder. Further review revealed a Diagnosis Report listing all resident #3 diagnoses which did not list a diagnosis of having a seizure disorder. During an interview on 02/03/2026 at approximately 10:00 AM staff member #8 stated and agreed, There is no diagnosis listed or medical documentation in resident #3 medical records confirming that resident #3 has a seizure disorder. On 02/03/2026 at 12:45 PM, after surveyor intervention, staff member #8 provided documentation revealing an updated medication order for resident #3 dated 02/03/2026 stating Lamotrigine Oral Tablet 200mg give 1 tablet by mouth one time a day for Bipolar Disorder.