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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215192 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Future Care Cherrywood | 12020 Reisterstown Road<br>Reisterstown, MD 21136 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Based on review of the medical record it was determined that the facility failed to develop a baseline care plan which included initial goals based on admission orders and the instructions needed to provide effective and person-centered care that met professional standards of quality care. This was evident for 1 (#2) of 3 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. A baseline care plan must be prepared for all residents within 48 hours of a resident's admission. Its purpose is to provide the minimum healthcare information necessary to properly care for a resident, including, but not limited to, the resident's initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services, until a comprehensive care plan can be completed for the resident. A summary of the baseline care plan as well as a list of the resident's current medications must be given to each resident. On 4/10/26 at 10:39 AM, a review of a complaint #2807352 alleged Resident #2 had not received adequate care at the facility. A review of Resident #2's medical record was conducted on 4/19/26 at 11:00 AM and revealed the resident was admitted to the facility for rehab in the beginning of March 2026 following an acute hospitalization for acute respiratory failure and a pulmonary embolism (blood clot) and with multiple diagnosis including pulmonary (lung) fibrosis (disease causing damaged, scarred lungs), chronic respiratory failure with hypoxia (low oxygen in tissues), pneumonia and diabetes. Later, in March 2026, Resident #2 had a change in condition, transferred back to the hospital and subsequently discharged from the facility. In an admission History and Physical note, on 3/11/26, the attending physician documented that prior to his/her admission to the facility, Resident #2 had been hospitalized for acute hypoxic respiratory failure and an acute pulmonary embolism and the resident's past medical history included pulmonary fibrosis, with severe restrictive pulmonary disease, Interstitial lung disease (ILD) (causes lung inflammation and scarring), and diabetes. A review of Resident #2's March 2026 medication administration record (MAR) on 4/10/26 at 2:25 PM, revealed admission orders for respiratory medications, initiated on 3/11/26 that included:- Jascayd (nerandomilast) tablet by mouth two times a day for pulmonary fibrosis- Prednisone tablet by mouth one time a day for interstitial lung disease that was initiated on 3/11/26.- Ipratropium Albuterol Solution inhale orally every 6 hours for shortness of breath/wheezing.- Sulfamethoxazole/Trimethoprim (Bactrim) tablet by mouth one time a day for pneumocystis jirovecii pneumonia (fungal lung infection) prophylaxis (prevention)- Guaifenesin (expectant) (thins respiratory mucus) ER (extended release) by mouth every 12 hours for cough The MAR also documented 3/11/26 admission medication orders that included:- Humalog (insulin lispro) KwikPen injector Inject subcutaneously, as per sliding scale, before meals and at bedtime for Diabetes.- Apixaban (Eliquis) (anticoagulant) (blood thinner) tablet by mouth 2 times a day for anticoagulant that was initiated on 3/11/26.A review of Resident #2's March 2026 treatment administration record (TAR) revealed a 3/11/26 order for Oxygen via nasal cannula at 3 LPM (liters per minute) initiated on 3/11/26 that documented the resident used oxygen continuously every day. Further review of Resident #2's medical record revealed a Baseline Care Plan Summary with an effective date of 3/11/26 at 6:29 AM<br>(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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| NAME OF PROVIDER OR SUPPLIER Future Care Cherrywood | | STREET ADDRESS, CITY, STATE, ZIP CODE 12020 Reisterstown Road Reisterstown, MD 21136 | |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that had an initial admission goal to discharge to the community, a discharge goal to return to the community, and a functional goal to improve functional status. The care plan failed to include the minimum healthcare information with initial goals and interim approaches to manage Resident #2's respiratory needs, his/her diabetes and the resident's use of an anticoagulant. Review of Resident #2's comprehensive care plans revealed a care plan for pain, falls, self-care deficit, skin integrity, and nutrition, had been developed within 48 hours of his/her admission to the facility, however there was no evidence that a care plan addressing Resident #2's respiratory status, diabetes, or use of an anticoagulant had been developed within 48 hours of the resident's admission or while s/he resided in the facility. On 4/13/26 at 2:20 PM, the above concerns were discussed with the Nursing Home Administrator (NHA) and Director of Nurses (DON). The NHA and the DON acknowledged the concerns and offered no further comments at that time. |