STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215192	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Cherrywood	12020 Reisterstown Road 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 (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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure advance directives were offered and documented upon admission for 5 (Residents #1, #2, #5, #70, and #159) of 9 residents reviewed.The findings include:On 9/25/25 at 9:38 AM, review of the electronic medical record for 9 residents revealed that advance directive documentation could not be located for 5 residents (#1, #2, #5, #70, and #159). At 10:15 AM on the same day, surveyor requested documentation from facility staff.On 9/25/25 at 11:40 AM, an interview was conducted with Staff #10 who reviewed the residents' admission dates and facility records. Staff #10 stated:Resident #1 was admitted on [DATE] and was offered an advance directive on 9/8/25.Resident #2 was admitted on [DATE] and was not offered an advance directive until 9/25/25 after the surveyor had requested the documentation.Resident #5 was admitted on [DATE] and declined an advance directive on 8/21/25.Resident #70 was admitted on [DATE] and declined an advance directive on 8/19/25.Resident #159 was admitted on [DATE] and was not offered an advance directive until 9/25/25 after the surveyor had requested the documentation.Documentation presented by Staff #10 at this time was reviewed and the dates were confirmed to be correct.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to ensure that Resident #36 was provided assistance with meals in a manner that promoted dignity and respect. The failure resulted in the resident's meal tray being left unopened at bedside without staff assistance. Findings include:On 9/25/25 at 9:00 AM, during observation rounds, Resident #36 was observed with his/her meal tray on the bedside table. The tray remained unopened, and the resident made no attempt to self-feed.Interview on 9/25/25 at 9:10am with Geriatric Nursing Assistant (GNA) #19, assigned to Resident #36, revealed that she had assisted the resident with morning care but stated that the resident required assistance with meals. GNA #19 reported that she believed another GNA had been assigned to provide feeding assistance to the resident.During an interview on 9/25/25 at 9:20am, GNA #22 (identified by the facility assignment board as the GNA assigned to feed the resident) stated he was unaware that he had been assigned to feed Resident # 36. At the time of the observation, other residents' trays were being collected, while Resident #36 tray remained untouched.On 9/25/25 at 10am interviews with the Director of Nursing (DON) and Unit Manager staff #12 confirmed the resident required assistance with meals and that the staff miscommunication led to the tray being left at bedside without feeding assistance. The DON stated the issue was corrected immediately after notification.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and facility staff interviews, it was determined that the facility failed to notify the court-appointed representative of the resident's discharge and to have that representative involved in discharge planning. This was evident for 1 (Resident #161) out of 1 residents reviewed for court-appointed guardianship.The findings include: On October 1, 2025, at 9:21 AM, the NHA and DON were interviewed in reference to the resident having a court-appointed guardian. The DON stated that the facility did not know that the resident had a court-appointed guardian. The facility had assumed that the resident was to return to the assisted living facility where he/she had previously resided. The NHA stated that the caregiver from the facility had been involved in the resident's affairs from the beginning. The caregiver had been in touch with the facility about the resident's discharge planning and was there to pick up the resident when she was discharged from the facility. The DON and NHA felt that they were familiar enough with the resident from prior admissions. The DON stated that the information on the discharge summary from the hospital stating that the resident's guardianship was complete was overlooked and not included in the resident's medical records.On October 1, 2025, a review of medical records revealed that the hospital discharge summary, on the first page, stated that the guardianship process had been completed and that the resident was not competent enough to make their own medical decisions. The resident had been admitted to the facility on [DATE], and the court order was completed on March 28, 2025. Further review revealed that on April 16, 2025, during the follow-up visit with the CRNP, she stated in her note that the resident's guardianship process had been completed during the resident's last hospitalization.During this investigation, it was determined that the facility failed to notify the court-appointed guardian of the resident's discharge.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on medical record review and interviews with facility staff it was determined the facility staff neglected to provide continence care to a resident who was dependent on staff for assistance. This was found to be evident for 1 (Resident #139) of 5 residents reviewed for Accidents during the facility's survey.Findings include,Resident # 139 was admitted to the facility with the following but not limited to diagnosis; Dementia (decline in cognitive function) and History of Falling.Medical record review on 9/29/25 at 10:10AM revealed the resident had a fall on 7/10/25. Review of the fall investigation provided by the facility revealed the resident was found on the floor by Geriatric Nurse Assistant (GNA # 8) on 7/10/25 at approximately 8:30AM. The resident did not sustain an injury. The resident was found to be soiled and agitated per the investigation.During an interview with the Director of Nursing (DON), on the same date at 11:20 AM, she stated that GNA (#7) who worked the night shift did not provide continence care (support management) to the resident who was incontinent (involuntary loss of urine or stool) before leaving at 7:00AM when her shift ended. She further stated that the oncoming GNA confirmed that the resident was soiled. The DON stated that GNA # 7, who worked for an agency was placed on the facility's do not return list due to resident neglect. All concerns were discussed with the Administration team at the exit conference on 10/1/25.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, it was determined that the facility failed to involve the court-appointed representative in the development of the discharge plan and failed to ensure that the assisted living facility was a licensed facility for safe discharge. This was evident for 1 (Resident #161) out of 1 residents reviewed for safe discharge.The findings include: On October 1, 2025, at 9:21 AM, the NHA and DON were interviewed in reference to the resident having a court-appointed guardian. The DON stated that the facility didn't know that the resident had a court-appointed guardian. The facility had assumed that the resident was to return to the Assisted Living facility where she had previously been. The NHA stated that the caregiver from the facility had been involved in the resident's affairs from the beginning. The caregiver had been in touch with the facility about the resident's discharge planning and was there to pick up the resident when he/she was discharged from the facility. The DON and NHA felt that they were familiar enough with the resident from prior admissions. The DON stated that the information on the discharge summary from the hospital stating that the resident's guardianship was complete was overlooked and not included in the resident's medical records.On October 1, 2025, a review of medical records revealed that the hospital discharge summary, on the first page, stated that the guardianship process had been completed and that the resident was not competent enough to make her own medical decisions. The resident had been admitted to the facility on [DATE], and the court order was completed on March 28, 2025. Further review revealed that on April 16, 2025, during the follow-up visit with the CRNP, she stated in her note that the resident's guardianship process had been completed during the resident's last hospitalization.During this investigation, it was determined that the facility failed to notify the court-appointed guardian of the resident's discharge and failed to ensure that the Assisted Living facility was a licensed facility for a safe discharge.

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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 in staff interviews and record review, it was determined that the facility failed to notify and coordinate with the court-appointed guardian of the resident for discharge proceedings to ensure a safe discharge. This was evident for 1 (Resident #161) out of 1 residents reviewed for safe discharge.The findings include: On October 1, 2025, at 9:21 AM, the NHA and DON were interviewed in reference to the resident having a court-appointed guardian. The DON stated that the facility didn't know that the resident had a court-appointed guardian. The facility had assumed that the resident was to return to the Assisted living facility where she had previously been. The NHA stated that the caregiver from the facility had been involved in the resident's affairs from the beginning. The caregiver had been in touch with the facility about the resident's discharge planning and was there to pick up the resident when she was discharged from the facility. The DON and NHA felt that they were familiar enough with the resident from prior admissions. The DON stated that the information on the discharge summary from the hospital stating that the resident's guardianship was complete was overlooked and not included in the resident's medical records.On October 1, 2025 at 10 AM, a review of medical records revealed that the hospital discharge summary, on the first page, stated that the guardianship process had been completed and that the resident was not competent enough to make her own medical decisions. The resident had been admitted to the facility on [DATE], and the court order was completed on March 28, 2025. Further review revealed that on April 16, 2025, during the follow-up visit with the CRNP, she stated in her note that the resident's guardianship process had been completed during the resident's last hospitalization.Review of the assisted living facility revealed that it was not a licensed assisted living facility at all and that the caregiver was the owner of transitional housing. The website for this transitional housing stated that they provide supportive housing for homeless persons, which provides them with wrap-around support services that create a continuum of care and stability.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, medical record review and interviews with facility staff it was determined the facility staff failed to follow professional standards of practice when administering medications to a resident. This was found to be evident during medication administration observation for 1 (Resident # 20) of 49 resident's observed during the survey.The findings include: On 9/26/25 at 08:00AM a medication administration observation was done for Resident # 20. The nurse (Registered Nurse # 9) poured the resident's scheduled 8:00AM medications into a medication cup. In addition to the scheduled medications, the nurse poured Baclofen 5 mg (1) tablet into the medication cup. The nurse stated that although the medication is not scheduled until 10:00AM the resident likes to receive the Baclofen 5 mg tablet with his/her 8:00 medications.A review of the physician orders on the same date for Resident # 20 on the same date revealed the following: Baclofen 5 mg 1 tablet po (by mouth) tid (three times daily). The scheduled administration times were 10:00AM 14:00 PM (4:00PM and 22:00 (10:00PM)).An interview was conducted at 9:30AM with nurse (#9) and the Director of Nursing (DON) who was present. The nurse was asked about the Baclofen 5 mg tablet that was administered before the scheduled time and if it was the standard of practice to administer the medication outside of the scheduled time. The nurse stated that she should have called the physician first to get an order to give the medication early if the resident requested it to be given earlier than it's scheduled time. The DON confirmed that the physician should have been called for a resident request to have scheduled medication administered early, before administering the medication to the resident at the wrong time. The DON stated that re-education will be provided.The NHA was made aware of the concerns at 11:50AM.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observation and interview, it was determined that the facility failed to ensure a resident's dignity, respect, and quality of life by not providing access to a call bell. This deficient practice was evident for 1 (Resident #159) of 10 residents reviewed for dignity concerns. The findings include:On 9/29/25 at 1:26 PM, Resident #159 stated he/she had been sitting in the wheelchair since 11:00 AM and did not have access to the call bell. Observation revealed the resident's call bell was wrapped around the bedrail of the bed, positioned behind the resident and out of reach.On 9/29/25 at 1:28 PM, the Director of Nursing was notified of the finding. The DON entered the room with the nurse assigned to Resident #159 and conducted bedside education on proper call bell placement to ensure resident access.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on record review and interviews, it was determined that the facility failed to ensure nursing staff were licensed, certified, or registered in accordance with applicable State laws. This deficient practice was evident for 1 (Staff #3) of 2 staff reviewed.The findings include:On 9/24/25 at 7:58 AM, during the initial tour of Unit 3, the dry erase board was observed to list Staff #3 as a Registered Nurse (RN) assigned to residents. At 8:33 AM the same day, Staff #3 was observed wearing an identification badge displaying RN.On 9/26/25 at 10:47 AM, review of Staff #3's personnel file revealed documentation of an active Licensed Practical Nurse (LPN) license. Verification with the Maryland Board of Nursing confirmed that Staff #3 had an active LPN license only, with no active RN license. The record indicated a prior RN application denied in 2016, with the status still listed as pending. During the same review, Staff #11 and the Nursing Home Administrator were interviewed and confirmed the discrepancy. Staff #11 stated they believed Staff #3 held a New Mexico RN license.On 9/29/25 at 1:11 PM, review of the electronic medical record revealed that Staff #3 was listed in the charting system as an RN. At 1:19 PM, the Nursing Home Administrator was notified that Staff #3 was documenting under the RN designation.On 9/29/25 at 1:50 PM, an interview was conducted with Staff #3, who stated they had been living in Maryland for about one year. Their license reflected a Maryland address with an issue date of 6/24/22, over three years ago. Staff #3 stated they had originally applied for RN licensure in Maryland in 2016, later obtained an RN license in New Mexico after moving there in 2021, and acknowledged they were required to update their license for Maryland.

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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 record review and interviews, it was determined that the facility failed to maintain accurate and complete records for residents. This deficient practice was evident for 2 (Residents #139 and #161) of 3 residents reviewed during the facility's recertification survey. The findings include: 1.) Medical record review on 9/29/25 at 10:10AM revealed Resident # 139 was admitted to the facility with the following but not limited to diagnosis: Dementia and had a fall on 7/10/25. Review of the fall investigation provided by the facility revealed the resident was found on the floor by GNA (#8) on 7/10/25 at approximately 8:30AM. Further review of the resident care plan for actual falls did not have documentation of the fall or interventions. The last update to the resident care plan was dated 10/7/21. During an interview with the DON on the same date at 10:40 AM, she was asked if the resident care plan was updated after the resident was found on the floor by the GNA (#8) on 7/10/25. The DON stated that when a resident has a fall, the care plan is updated with interventions. She went on to explain that Resident # 139 care plan was closed in error on 8/25/25 and marked as resolved. She later provided documentation to the survey team of the documented error and the updated care plan. All concerns were discussed with the Administration team at the exit conference on 10/1/25. 2.) On October 1, 2025, at 9:21 AM, an interview with the facility's NHA and DON in reference to the resident's admission information. The DON stated that the facility didn't know that the resident had a guardian. The facility assumed the resident was to return to the facility where he/she was previously. They felt they were familiar with the resident from prior admissions. The DON stated that the information on the discharge summary from the hospital stating that the resident's guardianship was complete was overlooked and not included in the resident's medical records. On October 1, 2025 at 10 AM, a review of medical records revealed that the hospital discharge summary, located on the front page, stated that the guardianship process had been completed and that the resident was not competent enough to make her own medical decisions. The resident had been admitted to the facility on [DATE], and the court order was completed on March 28, 2025. Further review revealed that on April 16, 2025, during the follow-up visit with the CRNP, she stated that the resident's guardianship process had been completed during the resident's last hospitalization. Review of the face sheet showed Resident #161 was their own responsible party and that the owner of the transitional housing was the resident's friend and emergency contact.

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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. Based on observation, interview, and record review, it was determined that the facility failed to implement infection prevention and control practices by not ensuring oxygen equipment was dated when placed into use and by not ensuring staff donned appropriate personal protective equipment (PPE) while providing care to a resident on Enhanced Barrier Precautions (EBP). This deficient practice was evident for 2 (Residents #70 and #17) of 30 residents reviewed for infection control practices during the facility's recertification survey.The findings include: 1.) On 9/24/25 at 8:33 AM, Resident #70 was observed with an oxygen setup. The humidifier bottle and oxygen tubing attached to the resident's oxygen concentrator were noted to be in use but were not dated. At that time, Surveyor located Staff #3, who was identified as responsible for the care of Resident #70. Staff #3 confirmed the humidifier bottle and tubing were in use and acknowledged that they were not dated as required. Staff #3 then obtained a new humidifier bottle and oxygen tubing, placed them on the resident's concentrator, and marked both with the date. On 9/26/25 at 2:00 PM, the Nursing Home Administrator was informed of the above findings. 2.) Enhanced Barrier Precautions (EBP) is an infection control practice, primarily in nursing homes, that requires staff to wear a gown and gloves during high-contact resident care activities to prevent the spread of multidrug-resistant organisms (MDROs). EBP is applied to residents infected or colonized with specific MDROs, those with wounds requiring dressings, or those with indwelling medical devices. During observation on 9/26/25 at 10:00 AM, Geriatric Nursing Assistant (GNA) #22 was observed providing morning activities of daily living (ADL) care to Resident # 17 without wearing a gown. A sign posted on Resident #17's door revealed the resident was on Enhanced Barrier Precautions (EBP). GNA #22 confirmed during an interview at that time that she had not donned a gown prior to providing care. At the same time, the Charge Nurse entered Resident #19's room with supplies to perform a wound dressing change. The Charge Nurse failed to don a gown while preparing to perform the treatment, despite the posted EBP signage. The Unit Manager entered the room and instructed the Charge Nurse to put on a gown. During the observed wound dressing procedure, the Charge Nurse failed to maintain aseptic technique. The Charge Nurse was observed using a pair of scissors that had been lying on the resident's bedside table without a clean or sterile surface. This created a risk for wound contamination. During an interview conducted on 9/26/25 at approximately 10:30 AM, the Unit Manager staff #12 stated that staff are required to wear appropriate PPE and maintain aseptic technique when providing care or treatment to residents on Enhanced Barrier Precautions. This deficient practice had the potential to expose Resident #19 and other residents to healthcare-associated infections due to failure to follow infection prevention and control standards.