STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215253	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Cold Spring	4700 Harford Road Baltimore, MD 21214

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 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 record review and interviews it was determined that the facility staff physically/verbally abused a resident. This deficient practice was evidenced in 1 (#126) of two facility reported incidents reviewed for alleged abuse during the recertification survey. The findings include:On 10/01/25 at 10:22 AM the surveyor reviewed the investigation related to Resident #126 allegation of abuse. According to the investigation on 03/27/25 Maintenance Assistant #38 reported he/she witnessed Geriatric Nursing Assistant (GNA)# 18 pull their hand back and swung hitting the resident on the left shoulder. The swung had enough force that Resident #126 stumbled back into the wardrobe armoire behind them. Director of Social Services #3 interviewed Resident #126 roommate who was in the room during the time of the alleged incident. The roommate did not see the incident but verbalized they heard Resident #126 yell, why did you hit me, and they heard a stumble. GNA #18 denied hitting the resident but told Resident #126, I'm going to bop you. Director of Social Services #3 interviewed Resident #126 and verbalized GNA #18 hit them with their key holder because he/she was not dressed. Further review of the investigation revealed GNA #18 was suspended pending investigation and terminated on 04/04/25. GNA #18 was also reported to the Maryland Board of Nursing. The complaint read on 03/27/25 GNA #18 was observed by Maintenance Assistant #38 strike Resident #126 with their fist in the chest inside the residents' room. A review of an Employee Disciplinary Form dated 03/27/25 revealed GNA #18 was late for work 15 times and was a No Call/No Show 20 times. The Incident Description read on 03/27/25 GNA #18 was observed by another employee strike Resident #126 with their fist in the chest inside the resident's room. The form was signed by Assistant Director of Nursing (ADON) #25 and dated/signed 04/04/24.On 10/02/25 at 11:26 AM during an interview with Regional Director of Operations # 37 verbalized the result of the investigation was inconclusive. They had concerns because Resident #126 told them GNA #18 did not hit them on the shoulder. They reported the incident to the board for further investigation. They know something happened; the resident was trying to walk out of the room naked, and the GNA was trying to redirect him. Resident #126 verbalized the GNA tapped me. They didn't know if Maintenance Assistant #38 had some type of interaction with the GNA. It could have happened the way Maintenance Assistant #38 reported. On 10/07/25 at 10:56 AM during an interview with Maintenance Assistant #38 the surveyor asked did he/she witness the GNA #18 hit Resident #126. Maintenance Assistant #38 verbalized yes. The surveyor asked did he/she have anything against GNA #18. Maintenance Director #38 verbalized they did not socialize; he/she just saw her around in the workplace.

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Number of residents sampled: Number of residents cited: Based on record review and interviews it was determined that the facility staff failed to notify the state agency within the two-hour allotted time frame. This deficient practice was evidenced in 2 (#124 & #126) of 3 facility reported incident investigations reviewed during the recertification survey. The findings include: On 09/30/25 at 12:59 PM a review of the facility's investigation of the facility reported incident related to Resident #124 revealed the facility staff became aware of the alleged incident on 06/26/25 at 6:50 AM. The incident was reported to the state agency on 06/26/25 at 9:23 AM which was outside of the two-hour allotted timeframe for reporting incidents. On 10/01/25 at 1:50 PM a review of the facility's investigation of the facility reported incident related to Resident #126 revealed the facility staff became aware of the alleged incident occurred on 03/27/25 at 1:40 PM. The incident was reported to the state agency on 03/27/25 at 03/27/25 at 3:51 PM, which was outside of the two-hour allotted timeframe for reporting incidents. On 10/02/25 at 9:44 AM the surveyor reported to Regional Clinical Service Manager #5 both incidents were reported to the state agency outside of the two hour allotted timeframe. During an interview with the Administrator on 10/06/25 at 12:21 PM the surveyor asked who is responsible for reporting incidents to the state agency and what is the timeframe when incidents should be reported. Incidents are reported to the state agency by the Administrator, Director of Nursing (DON) or the Assistant Director of Nursing (ADON). Allegations of abuse are reported to the state agency as soon as possible; within two hours.

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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 record review and interviews it was determined that the facility staff failed to follow the standard of practice for nurses as evidenced that a nurse failed to notify the physician when a resident refused a treatment and a nurse completed a Change in Condition Evaluation 11 days after the change occurred. This deficient practice was evidenced in 2 (#124 & #125) of 5 resident records reviewed during the recertification survey. The findings include: On 09/30/25 at 11:35 AM a review of Resident #124 electronic health record (EHR) revealed Registered Nurse (RN) #10 completed a change in condition evaluation on 07/07/25 and the form was back dated to 06/26/25. On 09/30/25 at 12:13 PM during an interview with the Director of Nursing (DON) the surveyor asked when the staff are expected to document when a change occurs with a resident. The DON verbalized a change in condition evaluation form should be completed before the end of the shift. The Unit Managers or supervisors are supposed to ensure the staff completes documentation in a timely manner. On 10/03/25 at 8:55 AM a review of Resident #125 electronic health record revealed Licensed Practical Nurse #35 documented on 8/5/2025 at 11:21 PM the resident refused care of their suprapubic catheter. Further review of the EHR revealed on 08/10/25 at 11: 12 PM LPN #35 documented the resident refused care of their suprapubic catheter. On 10/03/25 at 10:44 AM during an interview with Regional Clinical Service Manager #5 the surveyor asked when a resident refuses care what the staff are expected to do? Regional Clinical Service Manager #5 verbalized the staff should offer care to the resident again, call the family for assistance, and educate the resident about the implications of refusing care. The physician should be notified when a resident refuses care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews, and interviews, the facility staff failed to 1) obtain and administer medications according to procedures and, 2) failed to accurately and safely to conduct and apply before each meal's insulin sliding scale. This was evident for two residents (#133 and #43) out of 10 reviewed for medications. The findings include:1) On 10/6/25, at 1:06 PM, the surveyor reviewed Resident #133's medical record. The Medication Administration Record (MAR) for May 2024 indicated that four different medications were coded 9 (other, see progress notes) in the administration documentation. Three of those medications had progress notes that stated the medication was ordered, but the pharmacy still needed to deliver them to the facility. The medications were: Famotidine (start date of April 9, 2024) coded 9 on May 3, 2024. Levothyroxine (start date of December 2, 2023) coded 9 on May 29, 2024. Nasal Moist Nasal Solution (start date of May 25, 2024) coded 9 on May 26, 2024. On 10/6/25, at 1:02 PM, the surveyor interviewed Staff #5, the Regional Clinical Service Manager. During the interview, the surveyor reviewed the concern that Resident #133 did not receive his/her medication as ordered on multiple occasions because the medications were unavailable. Staff #5 stated that the pharmacy dispensed medications with three days' worth and replaced them accordingly. She further stated that the medications should have been available for administration. A review of the facility's policy, Medication Administration- Timeliness, revealed that the expected outcome stated, Medications will be administered within appropriate time frames. 2) On 10/2/2025 at 8:30 AM, this surveyor was on the floor to observe the medication administration with Registered Nurse (RN) Staff #16; noticing the residents' breakfast cart was arrived around 8:30 AM. Resident #43 had a standing order started 8/29/2025 for Humalog Kwikpen Subcutaneous Solutions pen-injector 100 Unit/ML (Insulin Lispro) injections as per sliding scale of the blood sugar (BS) fingerstick: if 0-200 =0, 201-25-=2, 251-300=4, 301-350=6, 351-400=8, 401+ =10 Notified MD if less than 60 or greater 400, subcutaneously before meals and at bedtime for Diabetes mellitus type 2. Humalog Kwikpen Insulin lispro U-100 (Humalog) is a short-acting insulin which Onset: 10-15 minutes Peak: 1-3 hours Administer 30-60 minutes before meals. Fingerstick is a method used to test blood glucose by using a puncturing device (like a lancet) to take a small sample of blood from the finger. Diabetes mellitus type 2 is a chronic metabolic disorder characterized by persistent high or low blood sugars. It may be due to impaired insulin secretion, resistance to peripheral actions of insulin, or both. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed Staff #16 was giving Resident #43's morning medications, he did not conduct the before breakfast BS check nor provided the proper coverage as an omission error. Noted on the Medication Administration Record (MAR) standard meals and before sleep hours BS checks were set for 6:30 AM, 11:00AM, 16:00 PM & 20:00 PM which it was also a concern. Record Review, on 10/2/2025 at 09:05 AM, MAR revealed that there was a discrepancy of breakfast sliding scale time set at 6:30 AM, however, the breakfast cart did not arrive until 8:30AM which it still required a before meal BS check to this resident. Interview, on 10/2/2025 at 09:20 AM, Unit Manager Staff #15 reviewed the MAR and stated that the night shift RN Staff #32 did a one time BS check around 6:00 AM the reading was 287 and she mistakenly utilized the before meal breakfast regiment then she covered Resident #43 with 4 units of Humalog Kwikpen Subcutaneous which it was an error. The day shift Staff #16 did not check at 8:30 AM when breakfast was served because he saw the before breakfast BS check was already filled in as 287 -2 hours ago. Staff #15 stated that the breakfast for that floor was always the last cart from the kitchen around 8:30 AM. Staff #15 was to correct all the before meal BS check times on MAR immediately to align with the actual meal serving times, to educate the nursing staff to conduct before meal time insulin scaling scale correctly and not to utilize the before meals insulin regiment for one time BS check needs. Interview, on 10/3/2025 at 10:00 AM, shared above finding with the Regional Clinical Service Manager Staff #5 as a practice concern. And she recognized that the above finding was a practice deficiency.