

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Future Care Sandtown-Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 North Gilmore Street Baltimore, MD 21217	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42863</p> <p>Based on interviews, medical record reviews, and record review, the facility failed to protect the residents' right to be free from neglect and failed to notify the medical staff, the facility administrative staff, and the resident's representative of a resident's change in condition in a timely manner. This was found to be true for 1 of 1 (#134) investigated for neglect during the survey.</p> <p>The findings include:</p> <p>On 01.30.25 at 3:00 PM the surveyor reviewed the complaint MD00197046 submitted to OHCQ on 09.18.23. The complainant addressed the late notification by the facility to the resident representative related to resident # 134's fall on 09.08.23 and delay in immediate care status post a fall.</p> <p>On 01.31.25 at 09:45 AM the regional district RN #17 provided the surveyor with the facility incident documents related to resident # 134. On one page of the hard copy facility incident report Resident had a fall on 09.08.23 without complaint of pain/visible injury was written by the director of nursing (DON). with a date of 09.10.23.</p> <p>Further review of the facility incident report included an interview conducted by the DON with LPN #25 via telephone on 09.10.23. The documentation stated that LPN #25 witnessed the resident fall on 09.08.23. LPN #25's statement included requested a [GNA #23's] assistance to return the resident to bed, the resident did not complain of pain, there were no visible injuries .and was returned to bed. The DON documented asking LPN #25 if it were possible that resident #134 hit his/her left hip during the fall and documented that LPN #25 responded Yes to the question. The DON documented that the interview was performed by telephone.</p> <p>On 02.03.25 at 1:30 PM the DON stated to the surveyor that LPN # 25 was informed by GNA # 23 of resident #134's fall on 09.08.23. The charge nurse, LPN # 26 did not notify the resident representative, the medical director, nurse practitioner, or the facility administrative staff. Additionally, LPN # 25 and LPN #26 did not document a physical assessment being conducted on 09.08.23 status post the fall of resident #134 in the electronic medical record per the DON.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01.31.25 at 1:30 PM the surveyor reviewed the facility incident report which revealed that on 09.09.23 Resident #134 complained of pain at a 2/10 rating. An X-ray was ordered. The SBAR communication form completed by RN # 37 documented that at 1:07 PM resident # 134 complained of pain to left hip, staff noted slight swelling and discomfort on palpation to the left thigh. The X-ray results completed on 09.09.23 showed a left proximal femur fracture in subtrochanteric region fracture. The results of the X-ray were reported to the facility on 09.10.23 Resident #134 was sent to the hospital and notification of the resident responsible party completed on 09.10.23 at 06:30AM.</p> <p>The concerns for failure to take immediate action and notification post fall were discussed with the administrator, DON, and regional nursing manager and director prior to the exit conference.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42782</p> <p>Based on record review and interview it was determined that the facility staff failed to: 1.) report an allegation of abuse to the state agency within the 2-hour allotted timeframe; 2.) report episodes of a resident's falls in a timely manner to the resident representative, physician, and facility administrative staff; 3.) report the results of the final investigation within five working days to the Office of Health Care Quality (OHCQ) This was evident for 2 out of 12 facility reported incidents reviewed, 2 out 4 residents (#134 and Resident #40) reviewed intakes during the survey.</p> <p>The findings include:</p> <p>1. On 02/06/25 at 10:30 am a review of the Facility Reported Incident (FRI) involving Resident #66 revealed the alleged incident occurred on 01/30/25 during the 3:00 pm - 11:00 pm shift.</p> <p>On 02/06/25 at 12:15 pm the surveyor received a copy of the staffing sheet 01/30/25 for the 3 pm- 11 pm shift and realized the alleged perpetrator's name was not on the assignment sheet. At 12:35 pm the surveyor received the staffing sheet for 7 am - 3 pm shift and the alleged perpetrator's name was present. Additionally, surveyor received a copy of Registered Nurse # 37's time sheet for 01/30/25 day shift which revealed he/she clocked out at 4:24 pm.</p> <p>On 02/06/25 at 4:04 pm during an interview with Administrator #1 the surveyor made him/her aware the alleged incident occurred on 01/29/25 during the 3 pm - 11 pm shift. The surveyor interviewed Resident #66 and the alleged perpetrator Registered Nurse #37. Administrator #1 reported when they found out about an alleged case of abuse the incident is reported within 2 hours. Resident #66 told them on the 31st and was told it happened on the 30th. Administrator #1 was shocked that the dates were different and that's when he did the self-report. Administrator #1 was made aware that the resident told the surveyor the incident was reported in the morning of 01/30/25 and Director of Nursing #2 interviewed some of the staff who worked on 01/29/25 when the alleged incident occurred.</p> <p>42863</p> <p>2. On 01.30.25 at 3:00 PM the surveyor reviewed the complaint, MD00197046 submitted to OHCQ on 09.18.23. The complainant addressed the late notification by the facility to the resident representative related to resident # 134's fall on 09.08.23.</p> <p>On 01.31.25 at 09:45 AM the regional district RN #17 provided the surveyor with the facility incident documents related to resident # 134 which was investigated on 09.10.23 and 09.11.23. The document stated that the resident had a fall on 09.08.23 and was diagnosed with a fractured left hip on 09.10.23</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the facility incident report included an interview conducted by the DON with LPN #25 via telephone on 09.10.23. The documentation stated that LPN #25 witnessed the resident fall on 09.08.23. LPN #25's statement included requested a GNA #23's assistance to return the resident to bed, the resident did not complain of pain, there were no visible injuries .and was returned to bed. The DON documented asking LPN #25 if it were possible that resident #134 hit his/her left hip during the fall and documented that LPN #25 responded Yes to the question. The DON documented that the interview was performed by telephone.</p> <p>On 02.03.25 at 1:30 PM the DON stated to the surveyor that LPN # 25 was informed by GNA # 23 of resident #134's fall on 09.08.23. The charge nurse, LPN # 26 did not notify the resident representative, the medical director, nurse practitioner, or the facility administrative staff. Additionally, LPN # 25 and LPN #26 did not document a physical assessment being conducted on 09.08.23 status post the fall of resident #134 in the electronic medical record per the DON.</p> <p>On 01.31.25 at 1:30 PM the surveyor reviewed the facility incident report which revealed that on 09.09.23 Resident #134 complained of pain at a 2/10 rating. An X-ray was ordered. The SBAR communication form completed by RN # 37 documented that at 1:07 PM resident # 134 complained of pain to left hip, staff noted slight swelling and discomfort on palpation to the left thigh. The X-ray results completed on 09.09.23 showed a left proximal femur fracture in subtrochanteric region fracture. The results of the X-ray were reported to the facility on 09.10.23 Resident #134 was sent to the hospital and notification of the resident responsible party completed on 09.10.23 at 06:30AM.</p> <p>On 09.10.23 at 01:30 AM resident #134's fall incident that occurred on 09.08.23 was reported to the facility administrative staff per the facility incident report. The clinical incident report included a description of incident/issue: Resident had fall, family and MD notifications was late as written by the DON on 09.10.23. The facility failed to follow its own policy and procedure related to reporting resident fall. These deficient practices were discussed with the administrator, regional nurses, and the DON during the exit conference as well.</p> <p>49148</p> <p>3. On 2/4/2025 at 7:21AM, the Surveyor reviewed the investigative file for a facility reported incident MD00205043, reported by Resident #5 on 4/17/2024 at 2:00PM.</p> <p>Further review of the investigative file revealed that the facility initiated an investigation and submitted an initial report to OHCQ on 4/17/2024 at 4:30PM, within 24 hours of the allegation as required. The results of the final investigation were completed and submitted to OHCQ 4/24/2024 at 12:00PM.</p> <p>On 2/4/2025 at 9:22AM, an interview with the Nursing Home Administrator (NHA) confirmed that the results of a final investigation should be submitted to OHCQ within five working days of the incident.</p> <p>51788</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 01/30/25 at 10:58 AM, Resident #40's Facility Reported Incident Initial Report Form and Facility Reported Incident Follow-Up Investigation Report Form were reviewed. The Facility Reported Incident Initial Report Form revealed that the facility was made aware of the alleged abuse incident on 12/02/24 at 3:30 PM. The Facility Reported Incident Follow-Up Investigation Report Form revealed that the facility reported the results of the investigation to the State Survey Agency on 12/09/24 at 6:15 PM and was not within 5 working days.</p> <p>On 02/05/25 at 12:23 PM, staff RN Regional Clinical Services Manager #8 was interviewed. During the interview, staff RN Regional Clinical Services Manager #8 agreed that the facility reported the results of the investigation to the State Survey Agency, beyond 5 working days of the incident, on 12/09/24 at 6:15 PM.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>42782</p> <p>Based on observations and interviews it was determined that the facility staff failed to monitor a resident's oxygen saturation as ordered and failed to follow a physician's order for oxygen therapy. This deficient practice was evidenced in 1 (#80) of 1 resident assessed for oxygen therapy during the survey.</p> <p>The findings include:</p> <p>On 01/29/25 at 9:03 am the surveyor observed Resident #80 in bed receiving 3L of oxygen therapy via NC.</p> <p>On 01/30/25 at 12:58 pm the surveyor observed Resident #80 receiving 3 liters of oxygen (O2) therapy via nasal cannula (NC).</p> <p>On 01/31/25 9:29 am a review of the electronic medical record revealed an order was written on 11/24/24 for Resident #80 to receive 3L of oxygen via NC as needed (PRN) for shortness of breath (SOB) and pulse ox below 95%. A review of the resident's medication and treatment administration records for November 24, December 24, and January 25 revealed there was no documentation to support the resident was receiving oxygen therapy. A review of the resident's vital signs revealed the resident's oxygen saturation was not being checked daily. The surveyor observed the resident receiving oxygen therapy continuously for the past two days. The last documented oxygen saturation was 01/29/25 at 1:35 pm which was 98%. The previous oxygen saturation was documented on 01/22/25 at 5:07 pm with a result of 98%.</p> <p>On 01/31/24 at 1:41 pm during an interview with Registered Nurse #32 the surveyor asked if a resident is receiving oxygen therapy where it would be documented. RN #32 verbalized oxygen therapy would be documented on the treatment administration record. The surveyor made RN #32 aware Resident #80 was receiving oxygen therapy continuously and it was ordered PRN for a saturation below 95% and there was no documentation in the EMR to verify the resident was receiving the therapy. Also, the surveyor reported the resident's saturation has not been checked in two days. Nurse #32 confirmed the surveyor's findings.</p>