STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215271	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Sandtown-Winchester	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview with facility staff, it was determined that the facility failed to ensure that a physician was notified of laboratory results in a timely manner resulting in a delay in treatment. This was evident for 1 (Resident #4) out of 5 residents reviewed during a complaint survey. The findings include:On 10/20/25 at 8:12 AM review of complaint 2589012 revealed the complainant had stated Resident #4 has had to be transported to the hospital for a UTI (urinary tract infection) on several occasions due to lack of care from the staff. Resident #4's medical record was reviewed on 10/20/25 at 12:01 PM and revealed an order dated 4/29/25, Obtain UA/C & S (urine analysis and culture and sensitivity) to R/O (rule out) UTI on 4/30/25 am. On 10/21/25 at 10:38 AM in an interview with the Director of Nursing (DON) and Regional Clinical Services Manager (RCSM) when asked the protocol/process when a resident was ordered labs, the RCSM stated the nurse put the order into Diamond Lab and then they come and draw/collect it. Then, Diamond Labs uploaded the results into PCC (the facility's electronic medical record). The results were in the Dashboard when the nurses, doctors and unit managers logged into PCC. When asked if they received a notification when labs resulted, she stated there was no alerting system, but they knew about when the labs were going to result and were checking. When asked the process if a urine specimen resulted positive for a UTI, she stated the doctor/NP (Nurse Practitioner) would be notified and we would follow his orders. When asked the time frame for the process, she stated as soon as it was verified, but within the shift. The Lab Results Report for Resident #4's urine analysis and culture and sensitivity was reviewed on 10/21/25 at 12:50 PM and revealed, Collection Date: 5/1/25 11:40 AM, Received Date: 5/1/25 11:40 AM, and Reported Date: 5/4/25 10:01 AM. Additionally, it documented that the results were reviewed on 05/05/2025 12:33 PM, a day after the labs resulted. Resident #4's medical record was reviewed on 10/20/25 at 9:53 AM. The review failed to reveal provider notification of the abnormal lab results on the day the lab resulted, 5/4/25. Further review revealed a progress note dated 5/5/25 at 3:02 PM which documented, LAB/RAD Notes: Late Entry: Note Text: Labs reviewed r/p (responsible party) and MD/CRNP aware will follow approaches and monitor. On 10/21/25 at 10:18 AM review of Resident #4's medical record revealed was s/he ordered the following antibiotic: Order date: 5/5/25 9:00 PM Macrobid Oral Capsule 100 MG (milligrams). Give 1 capsule by mouth two times a day for UTI for 7 Days; however, it was not ordered until 25 hours after his/her urine labs had resulted. The surveyor shared this was a concern and the RCSM confirmed and verified understanding. On 10/21/25 at 1:41 PM in an interview with the DON and RCSM, the DON provided a note from the facility's NP addressing the urine results; however, it was dated 5/5/25 at 4:47 PM the day after the urine resulted. The surveyor reiterated this was still a concern and the RCSM stated, We're on the same page. There is no evidence or documentation that the urine results were addressed by a provider the day they resulted. During the interview, she stated the Assistant Director of Nursing (ADON) was reaching out to the nurse for Resident #4 on 5/4/25 to see if she notified anyone of the results, but she stated as of now she had no evidence. At the time of survey exit, 10/21/25 at 2:32 PM, the concern was shared again and the facility provided no further information or documentation.

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