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Form Approved OMB
No. 0938-0391

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	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 49148 Based on record review and interviews with facility staff, it was determined that the facility failed to provide an environment that promotes resident respect and dignity. This was evident for 2 (Resident #10 and #34) out of 4 residents reviewed for dignity during the survey. The findings include: 1. On 1/30/2025 at 9:15AM, the Surveyor conducted an interview with Resident #10 in his/her room. The resident informed the Surveyor that if he/she must try to get all of his/her cares done on the 3PM-11PM shift because the nursing staff will not check on him/her or answer the call bell overnight. If the resident has a bowel movement or urinates in their diaper from 11PM-6AM, that he/she has to sit in it until someone does rounds after 6AM. BIMS stands for Brief Interview for Mental Status, a cognitive screening tool used to assess a person's mental status and scored from 0-15. During a review of Resident #10's electronic medical record, the Surveyor discovered that the resident had a BIMS score of 15, indicating the resident was cognitively intact. Further review revealed the resident was dependent on nursing staff for activities of daily living and was bedbound with bilateral hand and feet contractures. During a review of the Geriatric Nursing Assistant (GNA) Point of Care documentation for January 2025 on 2/5/2025 at 8AM, the Surveyor discovered that the Resident #10 was provided bowel and bladder incontinent care 1/2/2025 at 10:56PM and then 1/3/2025 at 7:50AM, 1/4/2025 at 11:11PM and then 1/5/2025 at 1:27PM, 1/5/2025 at 11:27PM then 1/6/2025 at 8:02AM, 1/6/2025 at 8:02AM and then 1/7/2025 at 7:41AM, 1/8/2025 at 12:53AM and then 1/8/2025 at 1:54PM, 1/8/2025 at 11:27PM and then 1/9/2025 at 7:31AM, 1/12/2025 at 1:34PM and then 1/13/2025 at 6:59AM, 1/13/2025 at 11:10PM and then 1/14/2025 at 9:08AM, 1/20/2025 at 9:53PM and then 1/21/2025 at 7:22AM, 1/22/2025 at 11:06PM and then 1/23/2025 at 1:46PM, 1/25/2025 at 10:59PM and then 1/26/2025 at 1:36PM, and 1/29/2025 at 9:33PM and then 1/30/2025 at 2:34PM. On 2/6/2025 at approximately 3:30PM, the Nursing Home Administrator (NHA) informed the Surveyor that the facility does not keep a record of call bell logs by room and the duration of time it takes for staff to respond to the call bells. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/29/2025 at 12:41PM, the Surveyor conducted an interview with Resident #34. During the interview, the resident stated that Geriatric Nursing Assistant (GNA) #50 speaks to you like you nothing. The resident stated that he/she reported how they felt to the facility and didn't want to work with GNA #50 any longer. The resident stated that he/she was assigned to GNA#50 recently but never told the facility he/she wanted to be assigned to GNA #50. During further interview with Resident #34, the Surveyor was informed that GNA #51 washed the resident's face with a washcloth that had feces on it. The resident reported his/her concern to the facility and did not want to be assigned to GNA #51 any longer. The resident stated that he/she was recently assigned to GNA #51. On 1/30/2025 at 12:30PM, the Surveyor reviewed Resident Concern Forms for Resident #34. On 6/7/2024 Resident #34 filed a grievance with the Nursing Home Administrator (NHA) against GNA #50 which stated GNA #50 at times has an attitude when working with her/him. GNA #50 was educated and signed the Employee Education Form which included, [GNA #50] is no longer assigned to the resident. On 6/7/2024 Resident #34 filed a grievance with the NHA against GNA #51 which stated that about 3 weeks ago, [GNA #51] was providing activity of daily living care to the resident and GNA #51 washed the resident's face with a washcloth that had feces on it. GNA #51 was educated and signed the Employee Education Form which included, [GNA #51] is no longer assigned to the resident. On 2/5/2025 at 9:50AM, during an interview conducted with the Director of Nursing (DON), the Surveyor was informed that once a resident expresses that they don't want to work with a staff member, she would talk with the resident to find out why, fill out a Resident Concern Form, and start an investigation if needed. That staff member is taken off the resident's assignment and will not work with that resident again unless the resident says they want them back. On 2/5/2025 at 11:41AM, a review of the Daily Unit Staffing and Assignment Forms for Unit 4 from 1/30/2025 through 2/3/2025 revealed that Resident #34 was assigned to GNA #50 on 2/3/2025 for the 7AM-3PM shift and assigned to GNA #51 on 2/1/2025 for the 3PM-11PM shift and 2/2/2025 for the 3PM-11PM shift. On 2/5/2025 at 3:00PM, during an interview with the NHA and Regional Clinical Service Nurse #17, the Surveyor expressed the concern that Resident #34 was assigned to work with GNA #50 and GNA #51 even though they were to no longer be assigned to the resident as stated in the employee education on 6/7/2024 and the resident did not request them.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 51129 Based on observation and interview, it was determined that the facility failed to ensure that call bells were kept within reach for residents to utilize. This deficient practice was evidenced in 5 (#57, #38, #66, #37 and #152) of 28 residents during the survey. The findings include: 1. On 2/3/2025 at approximately 9:30 AM, during a tour of the facility it was observed in Resident #57's room that the call bell was under the resident's bed. The call bell itself was a regular push-style call button that due to the resident's arm and hand contractures it would be difficult to use. During this tour, GNA #22 was asked where the call bell was. The GNA went to the head of the bed, reached under it and retrieved the call bell and attached it to the resident's bed sheet. The GNA stated that the resident couldn't communicate and wouldn't be able to use it anyway. When asked why they attached it to the bed sheet then, the GNA stated because the call bell was supposed to be within the resident's reach. On 2/3/2025 at approximately 1:00 pm, The Regional Clinical Services Manager #8 was made aware of where the call bell was found and what type it was. She was also made aware of GNA #22's response when made aware of the call bell not being available to the resident. After her investigation she reported that Resident #57's call bell had been replaced with a pressure sensor call bell that would be a more appropriate device so the resident could activate it. She also made the surveyor aware that GNA #22 had been educated on the issue. 2. On 01/29/25 at 8:39 am during observation rounds on Unit #5 the surveyor observed Resident #152 call bell on the floor on the right side of the bed. Geriatric Nursing Assistant #19 was made aware and provided the resident with the call bell. At 8:46 am the surveyor observed Resident #66 call bell under the left lower wheel of the bed. At 8:49 am the surveyor observed Resident #37 call bell on the floor on the upper left side of the bed and Resident # 38's call bell was clipped to the privacy curtain. GNA #18 was made aware that the residents did not have their call bells. On 02/06/25 at 3:44 pm during an interview with Assistant Director of Nursing (ADON) # 3 the surveyor asked what the expectation of the staff is to ensure the residents have their call bells. ADON #3 verbalized the residents call bells should always be in reach and the GNA's and nurses should make sure the residents have their call bells.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42782 Based on observations and interviews, it was determined that that facility staff failed to give residents the option of getting dressed and out of bed. This deficient practice was evidenced in 2 (Resident #37 and #50) assessed for Activities of Daily Living (ADL) choices during the survey. The findings include: During observation rounds on 01/29/24 at 9:20 am the surveyor observed Resident #37 in bed with a gown on. The resident verbalized he/she would like to get dressed and out of bed. At 9:36 am the surveyor observed Resident #50 in bed and the resident verbalized they are not able to get out of bed and get dressed. On 02/06/25 at 4:39 pm the surveyor made Director of Nursing (DON) #2 aware Resident's #37 & Resident #50 had been undressed and in bed every weekday during the past week. During an interview with DON #2 they verbalized the staff are expected to ask the residents if they want to get dressed and get out of bed. If the resident refuses the nurse should be made aware and a note should be written as it's the preference of the resident. There was no documentation to support the residents refused to get dressed or get out of bed.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 51129 Based on review of administrative records and interviews with staff, it was determined during the investigative phase of the survey, that the facility failed to permit 5 of 5 residents (#45, #72, #78, #67, #77) to access their personal funds. The findings include: On 8/6/2024 a complaint MD00208837 was submitted to the Office of Health Care Quality regarding the ability of the residents to access their personal funds. The surveyor interviewed Staff #52, the Business Office Manager on 2/4/2025 at 1:15 pm who stated that the Administrator, Staff #1 was aware of the need for petty cash to be available to the residents when she was not onsite. She provided The Resident Statements for 5 residents (#45, 72, 78, 67,77), the Surety Bond, a Trial Balance sheet and the Resident Trust fund policy. None of the Resident Statements had withdrawals on weekends or evenings with all transactions occurring Monday through Friday. The surveyor then Interviewed he Staff #1 on 2/4/2025 at 1:30 PM, he stated that there wasn't anyone on the weekends and evenings available to disperse resident funds unless he was in the building. When asked was he was frequently in the building on evenings and weekends, he stated he was rarely there after hours. He also stated that there was no petty cash available to be distributed by supervisors when the Business Office Manager was not onsite.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49148 Based on observation, record review, and interview with staff, the facility failed to ensure that a current copy of a resident's advance directive was in the resident's medical record and that every resident had the opportunity to execute an advanced directive. This was evident for 2 (Residents #7 and #46) out of 8 residents investigated for advanced directives during the survey. The findings include: Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor informs the medical staff that CPR should not be attempted. Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. 1. On [DATE] at 12:30PM a review of Resident #7's paper medical record revealed a MOLST form signed and dated [DATE], with a code status of No CPR. On [DATE] at 12:56PM, during a review of Resident #7's electronic medical record, the Surveyor discovered an Oral Advanced Directive form signed and dated [DATE] which stated, At this time, [Resident #7] would like CPR performed. Additional review revealed a Social Services Advanced Directive note written on [DATE] which stated that the Resident verbalized understanding of CPR, currently FULL CODE and requesting change to DNR. MOLST reviewed with [resident] and Health Care Agent. [Resident] is now NO CPR. On [DATE] at 10:51AM, during an interview conducted with Interim Social Work Director #45, in the presence of Regional Clinical Services Registered Nurse #17, the Surveyor confirmed that the MOLST form and the Advanced Directives documents should reflect the same code status for a resident to maintain accurate medical records. The Surveyor reviewed the concern that the current MOLST form in Resident #7's paper medical record stated NO CPR , which indicated the resident's current medical wishes and the current Oral Advanced Directive form in Resident #7's electronic medical record stated FULL CODE. 51788 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On [DATE] at 10:58 AM, Resident #46's medical record was reviewed. The medical record review revealed that Resident #46 did not have an advanced directive in place. On [DATE] at 11:11 AM, Resident #46 was interviewed. During the interview, resident #46 stated that the facility did not ask him/her if he/she wanted to complete an advance directive. On [DATE] at 12:41 PM, staff RN Regional Clinical Services Manager #17 was interviewed. During the interview, staff RN Regional Clinical Services Manager #17 stated that Social Work does not have an advance directive for Resident #46, and the facility does not have a progress note indicating that Resident #46 was presented with an opportunity to complete an advance directive.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51788 Based on observations and facility record reviews, it was determined that the facility failed to provide residents with a homelike environment in good repair. This was evident for resident bathrooms observed during the survey. The findings include: On 01/29/25 at 08:28 AM during observation rounds, room [ROOM NUMBER] bathroom was observed to have a cracked toilet seat. On 01/29/25 at 08:37 AM during observation rounds, room [ROOM NUMBER] bathroom was observed to have cracked caulking around the bathroom sink where it meets the wall. On 01/29/25 at 08:44 AM during observation rounds, room [ROOM NUMBER] bathroom was observed to have a hole in the wall behind the toilet, the cove base was separated and peeling from the wall, and the wall directly in front of the toilet had large pieces of dry wall missing. On 02/04/25 at 09:34 AM, the facility's pest control records were reviewed. The facility's pest control records revealed that when Orkin Pest Control services treated the facility on 02/03/25, they recommended that the facility seal the hole in the wall in room [ROOM NUMBER] bathroom.

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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. 42863 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. The findings include: 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. 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. 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. 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. 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. 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42782 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 andResident #40) reviewed intakes during the survey. The findings include: 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. 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, suveyor 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. 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. 42863 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. 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 49148 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. 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. 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. 51788 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42782 Based on record review and interviews it was determined that the facility staff failed to complete a thorough investigation of an allegation of abuse. This deficient practice was evidenced in 1 (#66) of 1 Facility Reported Incident (FRI) reviewed during the survey. The findings include: 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. The surveyor requested and received a copy of the staffing sheets for Unit #5 when the alleged incident occurred. On 02/06/25 at 12:15 pm review of the staffing sheet 01/30/25 for the 3 pm- 11 pm shift revealed 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. Received a copy of Registered Nurse # 37 time sheet for 01/30/25 day shift which revealed he/she clocked out at 4:24 pm. Review of the interviews conducted by Director of Nursing #2 revealed all the staff who worked on Unit #5 when the alleged incident occurred were not interviewed. On 02/06/25 at 4:13 pm during an interview with Director of Nursing (DON) #2 the surveyor asked what constitutes a thorough investigation. DON #2 verbalized interviews are conducted by the involved residents, staff, and anyone involved in the situation. The surveyor asked would they interview all the staff who worked during the alleged incident. DON #2 verbalized depending on the situation or the incident they are investigating. The surveyor made DON#2 aware the staff who worked during the alleged incident of abuse. DON #2 verbalized they were off when the alleged incident occurred and an addendum to the investigation would be done.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on medical record review and interview, it was determined that the facility staff failed to: 1.) have quarterly care plan meetings; 2.) ensure a resident was offered the opportunity to participate in their care planning process by being invited to their care plan meeting; and 3.) complete resident care plan meetings that were prepared and revised by the entire interdisciplinary team. This was evident for: 2 (#37 & #121) of 2 resident records reviewed for care plan meeting, 2 (Resident #10, #39) out of 4 residents investigated for care planning during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. This helps to evaluate the effectiveness of the resident's care. 1. During observation rounds on 01/30/25 at 10:22 am the surveyor asked Resident #121 were participating in the care plan meetings. Resident #121 verbalized they were not having care plan meetings. On 01/31/25 at 10:29 am a review of Resident #121 electronic medical record revealed the resident's last admitted was 08/09/24. Further review of the EMR revealed the last documented care plan meeting note was 08/12/24. 2. On 01/31/25 at 11:45 am a review of Resident #37 EMR revealed the resident was admitted [DATE] the last documented social service note was 05/14/24. The last documented care plan meeting was held 08/26/21. There was a note indicating a meeting would be held on 04/28/22, but there was no note in the medical record to verify the meeting occurred. The surveyor received a copy of a care conference sign in sheet dated 10/30/24, but there was not a note in the EMR. Further review of the Resident Care Plan Attendance form revealed Resident #37 was not receiving quarterly care plan meetings. Regional Clinical Services Manager #17 was made aware. 49148 3 On 1/30/2025 at 9:15AM during an interview conducted with Resident #10, the Surveyor was informed that the resident was unaware of care plan meetings and would like the opportunity to participate in their plan of care. BIMS stands for Brief Interview for Mental Status, a cognitive screening tool used to assess a person's mental status and scored from 0-15. On 1/31/2025 at 10:39AM, during a review of Resident #10's electronic medical record, the Surveyor discovered that the resident had a BIMS score of 15, indicating the resident was cognitively intact. Further review of the electronic and paper medical record failed to reveal the resident was invited to or attended the care plan meeting on 1/16/2025. There was no documentation with an explanation as to why Resident #10 did not participate in his/her care planning process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/2025 at 11:45AM, the Surveyor reviewed the facility's Assessment of Residents: Care Planning Process. According to the policy under Scheduling of Care Plan Conferences #3, the resident and his/her family member/significant other shall be notified of the care planning process and shall be notified in advance of each care planning conference. Also, under Documentation #1, attendees at the Care Plan Conference shall indicate their presence by signing the Resident Care Plan Attendance record. On 1/31/2025 at 12:50PM, during a review of Resident #10's Resident Care Plan Attendance date of conference 1/16/2025, the Surveyor noticed that Resident #10 was not on the list of attendees. The Nursing Home Administrator (NHA) and the Regional Clinical Service Nurse were asked to provide the Surveyor with documentation to verify Resident #10 was invited to the care plan meeting on 1/16/2025. As of 1/31/2025 at 2:15PM, the NHA and the Regional Clinical Service Nurse failed to provide the Surveyor with documentation that Resident #10 was invited to participate in their care plan meeting. 51788 4. On 01/30/25 at 01:39 PM, Resident #39's medical record was reviewed. The medical record review revealed that Resident #39's Resident Care Plan Attendance sheet, dated 01/28/25, showed that Dietary, an LPN and Rehab were the only interdisciplinary team members who attended Resident #39's care plan meeting on 01/28/25. On 01/31/25 at 11:00 AM, staff Social Work Assistant #43 was interviewed. During the interview, staff Social Work Assistant #43 stated that the typical interdisciplinary team members who attend resident care plan meetings are Rehab, Nursing, Dietary and Activities.

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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. 42782 Based on record review and interviews it was determined that the facility staff failed to practice according to professional nursing standards as evidenced by failing to complete a narcotic count prior to their shift and failing to sign the narcotic sheet after completing the narcotic count. This deficient practice was discovered during the survey. The findings include: On 02/04/25 at 1:45 pm the surveyor asked Licensed Practical Nurse (LPN) #30 who completed the narcotic count with them when their shift started. LPN #30 verbalized the narcotic count was completed with Unit Manager #34. The surveyor looked at the narcotic sign off sheet and did not see Unit Manager #34's name. The surveyor asked who signed the narcotic sheet. LPN #30 verbalized, oh that's right I did the count with Registered Nurse #33. The controlled narcotics sheet was signed by LPN #30 and RN #33. On 02/04/25 at 2:00 pm while on the third floor, the surveyor asked Registered Nurse # 33 who completed the narcotic count. RN #33 verbalized they completed the narcotic count with Registered Nurse #49 on the third and fifth floors that morning. Registered Nurse #33 worked on the fifth floor during the 11 pm - 7 am shift on 02/03/25. RN #49 did not sign the controlled substance form on Unit #5 after completing the count with RN #33. On 02/04/25 at 2:08 pm Director of Nursing #2 was made aware there LPN #30 told the surveyor two separate nurses completed the narcotic count with them that morning. RN #33 verbalized completing the narcotic count on Unit #5 with RN #49 but RN #49 did not sign the controlled substance form. DON #2 verbalized the nurses are supposed to complete the narcotic count and sign the sheet prior to their shift. On 02/04/25 at 3:08 pm the surveyor confirmed RN #33 and RN #49 completed the narcotic count on Unit #3 and Unit #5. RN #33 verbalized RN #49 wanted to make sure the count was correct before leaving the building. RN #49 worked on Unit #3 during the night shift on 02/03/25.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49148 Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure a resident had the opportunity to participate in daily activity programs and maintain documentation of resident participation. This was evident for 1 (Resident #10) out of 4 residents investigated for activities during the survey. The findings include: On 1/30/2025 at 9:08AM, the Surveyor conducted an interview with Resident #10 which revealed that the resident was not offered activities every day. The resident also stated that they used to participate in activities at the facility, but now it takes the staff too long to bring him/her back to their room when ready. BIMS stands for Brief Interview for Mental Status, a cognitive screening tool used to assess a person's mental status and scored from 0-15. During a review of Resident #10's electronic medical record, the Surveyor discovered that the resident had a BIMS score 15 indicating the resident was cognitively intact. Further review revealed the resident was dependent on nursing staff for activities of daily living and was transferred in and out of the bed using a mechanical lift device. The resident has bilateral hand and feet contractures and was bedbound. Additional review revealed that Resident #10 likes word search puzzles, listening to music, to do things in a group, talk shows, happy hour, baseball and football, and religious services. The resident needs escort assistance. On 2/3/2025 at 9:58AM, the Surveyor conducted an interview with the Activities Director (AD) #48. During the interview, the Surveyor was informed that activities are held every day in various activity rooms. The activity staff conduct room visits with bed bound residents and provide transportation to and from activities for those who require an escort. The Surveyor expressed the concern that Resident #10 was observed on 1/29/2025, 1/30/2025, 1/31/2025, and 2/3/2025 in their room with no activities at the bedside. The Surveyor also expressed the concern that the resident stated that he/she was not offered the opportunity to attend activities or have a one-on-one visits every day. The resident was not hands on and needed assistance with activities that he/she likes such as word search puzzles. AD #48 was made aware that the resident stated that he/she used to go to activities more when he/she was first admitted , but now it takes the staff too long to get the resident back to his/her room when he/she was ready to go back, and so at times, he/she declines. AD #48 confirmed that she hadn't seen Resident #10 participate in activities lately and did not inquire why he/she was not coming. AD #48 also has not made him/her a one on one room visit hoping he/she would come to the activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/2025 at 10:30AM, a review of Resident #10's Resident Participation Record revealed that Resident #10 was offered an activity 13 days in November 2024, 4 days in December 2024, 1 day in January 2025, and no days in February 2025. On January 21, 23, 28, and 30 it was documented that activity staff conducted a room visit with the resident. Further review failed to reveal documentation that activity staff offered the resident activities daily.

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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. 42782 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. The findings include: On 01/29/25 at 9:03 am the surveyor observed Resident #80 in bed receiving 3L of oxygen therapy via NC. On 01/30/25 at 12:58 pm the surveyor observed Resident #80 receiving 3 liters of oxygen (02) therapy via nasal cannula (NC). 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%. 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42782 Based on observation and interviews, it was determined that the facility staff failed to ensure a resident who smokes did not have readily available cigarettes. This deficient practice was evidenced in 1 (#6) of 1 residents assessed for safe smoking monitoring during the survey. The findings include: On 02/06/25 at 1:17 pm while the surveyor was on Unit #5 the surveyor noticed something on the floor in Resident #6's room. The surveyor walked into the room and observed a cigarette on the floor next to the bed in front of a black tennis shoe. Another cigarette along with unsmoked tobacco was on the floor in the walking path. The surveyor asked Registered Nurse #37 if Resident #6 was supposed to have their cigarettes. Registered Nurse #37 verbalized the resident was care planned for having their cigarettes. Review of Resident #6 care plans revealed, four separate care plans were initiated related to the resident smoking including adhering to the smoking policy. No interventions included monitoring the resident for smoking paraphernalia. On 02/06/25 at 2:50 pm the surveyor reported to Administrator #1 that Resident#6 had multiple cigarettes in their room. Administrator #1 verbalized the residents should not have cigarettes on hand.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49148 Based on observation, medical record review, and interview with staff, it was determined that the facility staff failed to provide care, treatment, and appropriate and sufficient services for a resident with an indwelling urinary catheter. This was evident for 2 (Resident #52, #50) of 3 residents reviewed for Urinary Catheters during the survey. The findings include: An indwelling urinary catheter is a thin flexible tube inserted through the urethra into the bladder to drain urine. The catheter is held in the bladder by a water-filled balloon, which prevents it falling out. These types of catheters are often known as Foley catheters. 1. On 1/30/2025 at 11:52AM, during an interview with Resident #52, the Surveyor observed the indwelling catheter bag with cloudy urine, hanging from the side bed frame facing the wall. On 2/3/2025 at 12:56PM, a review of Resident #52's electronic medical record failed to reveal physician orders for an indwelling catheter or for catheter care. The Treatment Administration Record (TAR) had no provision for the staff to sign off the presence of the indwelling catheter, size of catheter, monitoring or care provided for the resident related to the maintenance for the indwelling catheter such as changing the drainage bag, perineal and catheter care. During an additional review of Resident #52's electronic medical record, the Surveyor discovered a urology consultation note dated 9/6/2024 for urinary retention requiring an indwelling Foley catheter. The Urologist made recommendations to maintain Foley to SD for one more week, remove Foley for a repeat voiding trial, perform a bladder scan 6 hours post void, and straight catheter the resident for post void residual greater than 250ml for 3 days. If the resident failed the voiding trail, the Urologist wrote further instructions for treatment and services. There were no indwelling catheter orders in place after the urology consult. During an interview with the Director of Nursing (DON) on 2/3/2025 at 1:58PM, the Surveyor confirmed that there should be cleanse and care physician orders for residents with an indwelling catheter. The Surveyor asked the DON to provide documentation Resident #52's urology consult was reviewed by the physician and physician orders were initiated and implemented based on the urology consult. On 2/4/2025 at 8:03AM, the Regional Clinical Service Nurse #17 confirmed that there were no physician orders for Foley maintenance and care nor physician orders regarding the urology consult on 9/6/2024 for Resident #52. On 2/4/2025 at 9:03AM, during review of Resident #52's electronic medical record, the Surveyor observed new physician orders for a follow up with urology for urinary retention and indwelling care and maintenance placed on 2/3/2025. 2. On 01/31/25 at 9:41 am during observation rounds the surveyor observed Resident #50 in bed with an indwelling urinary catheter. The indwelling catheter tubing was cloudy with sediment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50 electronic medical record (EMR) on 02/03/25 at 10:27 am revealed an order was written on 08/22/24 at 9:50 pm that read Change catheter per physician order and PRN (10/10/24) Change catheter tubing and bag for malfunction, contamination, odor or sedimentation as needed. Review of the residents' medication and treatment administration records for the months of November & December 2024 and January 2025; there was no documentation to support the indwelling catheter or tubing had been changed. While on Unit #5 on 02/03/25 at 11:33 am the surveyor asked Registered Nurse (RN) #32 when the last time Resident #50 indwelling catheter was changed. RN #32 verbalized not being sure when the catheter was changed last but would check the medical record. RN #32 was unable to verify when the last time the indwelling catheter was changed. At 11:44 am RN #32 and the surveyor went to the resident's room and observed the indwelling catheter tubing was cloudy and had sediment. Also, the drainage bag was soiled with urine. RN #32 verbalized the catheter would be changed.

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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. 42782 Based on record review and interviews it was determined that the facility staff failed to ensure the controlled substance count was completed and the records were accurate. This was evident for 2 medication carts out of 4 medication carts reviewed during the survey. The findings include: 1. On 02/04/25 at 1:45 pm the surveyor asked Licensed Practical Nurse (LPN) #30 who completed the narcotic count with them when their shift started. LPN #30 verbalized the narcotic count was completed with Unit Manager #34. The surveyor looked at the narcotic sign off sheet and did not see Unit Manager #34 name. The surveyor asked who signed the narcotic sheet. LPN #30 verbalized, oh that's right I did the narcotic count with Registered Nurse #33. On 02/04/25 at 2:00 pm while on the third floor, the surveyor asked Registered Nurse # 33 who completed the narcotic count. RN #33 verbalized they completed the narcotic count with Registered Nurse #49 on the third and fifth floors. Registered Nurse #33 worked on the fifth floor during the 11 pm - 7 am on 02/03/25. On 02/04/25 at 2:08 pm Director of Nursing #2 was made aware there LPN #30 told the surveyor two separate nurses completed the narcotic count with them that morning. RN #33 verbalized completing the narcotic count on Unit #5 with RN #49 but RN #49 did not sign the controlled substance form. DON #2 verbalized the nurses are supposed to complete the narcotic count and sign the sheet prior to their shift. On 02/04/25 at 3:08 pm the surveyor confirmed RN #33 and RN #49 completed the narcotic counts on Unit #3 and Unit #5. RN #33 verbalized RN #49 wanted to make sure the count was correct before leaving the building. 51788 2. During review of facility Unit 2 medication cart #2 on 02/04/25 at 2:20 PM revealed that nightshift staff RN #37 and dayshift RN#36 completed a shift-to-shift narcotic count on 02/04/25 by signing on the facility's Shift-to Shift Narcotics Count form. On 02/04/25 at 02:22 PM, the dayshift staff RN #36 was interviewed. During the interview, the dayshift staff RN #36 stated that she did a shift-to-shift narcotics count with staff, RN, Unit Manager, (Unit 2) #27 not the nightshift staff RN #37, on the morning of 02/04/25, because the nightshift staff RN #37 had already left the facility. (continued on next page)

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	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/25 at 02:23 PM, the RN, Unit Manager # 27, was interviewed. During the interview, the RN, #27 stated that she did a shift-to-shift narcotics count with the dayshift staff RN #36 on the morning of 02/04/25, because the nightshift staff RN #37 had already left the facility. The RN, Unit Manager #27 also stated that she did not sign the Shift-to-Shift Narcotics Count Sheet and never signs the Shift-to-Shift Narcotics Count Sheet when she does a shift-to-shift narcotics count with the oncoming RN whenever the outgoing RN has already left the facility. On 02/05/25 at 01:33 PM, the facility's Narcotics: Counting policy was reviewed. The facility's Narcotics: Counting policy states that narcotics will be counted, and the narcotics audit form signed each time a nurse assumes responsibility for the cart (on going and off going nurses). On 02/06/25 at 12:13 PM, the facility's Punch Logs for the dayshift staff RN #36 and nightshift staff RN #37 were reviewed. The facility's Punch Logs for staff RN #36 and staff RN #37 shows that on the morning of 02/04/25, the nightshift staff RN #37 has an Out punch log of 02/04/25 at 7:26 AM, and the dayshift staff RN #36 has an In punch log of 02/04/25 at 8:52 AM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on observation and interview it was determined that the facility staff failed to store medication in the refrigerator, discard expired intravenous tubing kits, discard an opened gastrostomy tube, discard expired COVID-19 Rapid Test Kits, and an open vial of medication. This deficient practice was evidenced in 1 (Unit #5) of 2 medication storage units reviewed during the survey. The findings include: On [DATE] at 1:18 pm the surveyor reviewed the medication storage room on Unit 5. There was a pack of [NAME] cigarettes that belonged to a resident per RN Unit Manager #34 who the cigarettes were given to. A bag of 5 vials of Lorazepam was in the left upper cabinet on the second shelf behind a box. The bag had a label indicating the medication should have been refrigerated. The cap was removed from one vial and the vial was almost empty. The medication was prescribed for Resident #37. An opened package with a gastrostomy tube 14F/5ml was in the cabinet along with two packages of COVID 19 Rapid Test Kits that expired on [DATE]. One IV Start Kit expired on [DATE] and another expired on [DATE]. Licensed Practical Nurse #30 confirmed the surveyor's findings. The surveyor asked who was responsible for checking medications and other items in the medication storage room, LPN #30 verbalized being unsure. On [DATE] at 2:25 pm Director of Nursing #2 was made aware of the surveyor's findings in the medication room on Unit #5.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 42782 Based on observation and interviews it was determined that the facility staff failed to ensure a resident received dental care. This deficient practice was evidenced in 1 (#121) of 2 residents assessed for dental care during the survey. The findings include: On 01/30/25 at 10:23 am while speaking with Resident #121 the surveyor noticed the resident had two teeth; one in the right lower quadrant and one in the left lower quadrant. On 01/30/25 at 11:30 am the reported to the management team Resident #121 had poor dentition and asked if the resident had dental care since being admitted to the facility. On 02/03/25 at 8:45 am the surveyor received a copy of Health Drive request for Services/Consultation form for Resident #121. After surveyor intervention, the resident was ordered a consultation for dental care services. On 02/06/25 at 2:56 pm during an interview with Assistant Director of Nursing #3 he/she reported there was a referral process for prophylactic dental measures. The residents are seen but if they have pain or other issues they are referred as well and Long Term Care residents are referred to for dental care routinely.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51129 Based on resident interview, observation and staff interview, it was determined that the facility failed to provide food in accordance with the resident's preferences. This was evident in 1 of 1 (Resident #1) resident selected for review during the survey. The findings include: The surveyor interviewed resident #1 on 2/3/2025 at approximately 12:15 pm regarding their lunch tray. The resident stated that they never got what they wanted to eat. They also stated that I don't get to choose what I want on a daily basis. I was asked what I liked and didn't like when I first got here, but when the food gets to me, it usually nothing like what I said I liked. The surveyor observed the tray and reviewed the dietary slip on the tray. The tray had a very small hot dog on a plain piece of bread with no condiments available. According to the dietary sheet, there was supposed to be steamed broccoli but instead there was zucchini squash, which the resident had identified as a dislike. For dessert the resident had a plain unfrosted piece of cake that on the dietary slip was supposed to be a cranberry swirl cake. The resident had cranberry juice, they had identified as a dislike, hot tea with no sugar, sweeteners, or cream/creamer though they had identified wanting condiments for their beverages. The only item on their tray that was an item they wanted was noodles. The surveyor interviewed the Director of Food Services on 2/3/2025 at approximately 2:30 pm, who stated that the menu for the day and alternatives were posted on the unit but they could not guarantee that every resident that wanted to see the menu and any alternatives would be able to see it. The residents' dietary slips were only used by the dietary staff to be able to deliver the residents' tray to the appropriate resident. The confirmed that resident #1 dislikes on the lunch menu slip for 2/3/2025 was not honored.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51788 Based on observations and facility policy review, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety. The findings include: 1) During observation rounds with Director of Food Service staff #7 on 01/29/25 at 07:56 AM, the kitchen's dry goods storage room was observed to have sealed bins of flour, sugar, rice, and food thickener; canned beets and banana pudding; and bags of croutons without expiration dates labeled on them. During observation rounds with Director of Food Service on 01/29/25 at 08:09 AM, the kitchen's refrigerator was observed to have 9 Imperial chocolate shake cartons without expiration or a used by dates labeled on them. On 01/29/25 at 12:20 PM, the facility's Manufactured Food without Provided Use by Dating policy was reviewed. The facility's Manufactured Food without Provided Use by Dating policy states that when the facility receives manufactured products without a printed Use-By date on the original packaging, the facility will label and date the product, so it clearly shows a Received Date. The Received Date for the non-labeled manufactured products will become the facility's baseline date to establish the Use-by date from. The facility's Manufactured Food without Provided Use by Dating policy also states that the facility will refer to the following for general product guidelines: frozen products - 3 months; refrigerated products - 3 days; canned products - 2 years; and dried pastas/grain - 2 years. 2) During observation rounds on 02/03/25 at 11:56 AM, the kitchen's food serving line and preparation station for the resident's lunch time meal was observed to have cooked ground beef that had a temperature taken by staff [NAME] #28, using the facility's thermometer, at 140 degrees Fahrenheit. During observation rounds on 02/03/25 at 11:58 AM, the kitchen's food serving line and preparation station for the resident's lunch time meal was observed to have cooked pork that had a temperature taken by the Director of Food Service staff #7, using the facility's thermometer, at 130 degrees Fahrenheit.

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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. 49148 Based on observation, record review, and interview with staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices. This was evident for 2 (Resident #10 and Resident #86) out of 34 resident's paper medical record reviewed during the survey. The findings include: On 1/30/2025 at 12:17PM during a review of Resident #10's paper medical record, the Surveyor discovered an Anticoagulation Record form for Resident #86. On 1/30/2025 at 12:20PM, the Surveyor informed Unit Manager (UM) #44 of their observation. UM #44 was unable to explain how Resident #86's document was placed into Resident #10's paper medical record. UM #44 removed Resident #86's Anticoagulation Record form from Resident #10's paper medical record and placed in it the correct medical record for Resident #86.