STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215324	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Charles Village	2327 North Charles Street Baltimore, MD 21218

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview it was determined that the facility staff failed to complete a thorough investigation of an allegation of abuse as evidenced by staff who worked during the time of the alleged incident were not interviewed. This deficient practice was evidenced in 1 (Resident #8) of 5 investigations reviewed for the allegation of abuse during the compliant survey.The findings include:On 05/18/26 at 12:32 pm the surveyor reviewed the facility's investigation concerning an allegation of abuse concerning Resident #8. The staffing sheets were not included in the investigation; the surveyor asked Administrator #1 to provide the staffing sheets to be reviewed. A review of Unit 3 staffing sheets and staff interviews during the time of the alleged incident revealed there were no interviews/statements from three Geriatric Nursing Assistants (GNA) who worked when the alleged incident occurred. A review of the staffing sheet dated 12/10/25, 3 pm - 11 pm and the staffing sheet dated 12/11/25, 3 pm - 11 pm shift revealed GNA #16 worked on the unit. The staffing sheet dated 01/08/26 11 pm - 7 am shift revealed GNA # 18 worked on the unit. The staffing sheet dated 01/09/26, 3-11 pm shift revealed GNA #18 worked on the unit. The staffing sheet dated 01/09/26, 11pm - 7 am shift revealed GNA#19 worked on the unit. There were no statements/interviews included in the investigation from any GNA who worked during the shifts mentioned. On 05/18/26 at 9:52 am during an interview with Administrator #1 the surveyor asked to explain their process of completing an investigation. Administrator #1 verbalized the resident would be interviewed. They verify the concern. All allegations of abuse they report to OHCQ and the police. All the residents who are interviewable are interviewed. The residents who are unable to answer questions, a head-to-toe assessment would be completed. They go back three days and interview everyone who worked with the resident. They completed a general interview with all the staff that worked with Resident #8. If the resident does not know the exact date they go back 72 hours. If they know the time they interview the staff who worked during that time. Administrator #1 was made aware that three GNA's who worked during the time the alleged incident occurred were not interviewed. The surveyor confirmed the entire investigation was received prior to reviewing the documents.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on record review and interview, it was determined the facility failed to accurately document contact attempts for notification of a change in condition with resident representatives. This was evident for 1 of 2 complaints (Resident #3) reviewed during the survey. The findings include: Review of intake 2671400 on 5/15/26 at 9:15am revealed an allegation that facility nursing staff failed to notify the resident representative for Resident #3 of a change in condition. Review of Resident #3's medical records on 5/15/26 at 10:11am revealed change in condition documentation that revealed that the resident was observed by nursing staff to have had a change in mental status on 12/13/25. The change in mental status resulted in the resident being transferred to the local hospital for observation and treatment. The medical record documentation also revealed that the resident's son was notified of the change in condition and transfer to the local hospital. Further review of Resident #3's medical records on 5/15/26 at 11:30am revealed that the resident's daughter was listed as the 1st contact/resident representative. Continued review of Resident #3's medical record on 5/15/26 at 12:00pm revealed no evidence explaining the reason for failing to contact the resident's 1st contact/resident representative after the 12/13/25 change in condition incident. The surveyor interview of RN # 7 on 5/18/26 at 9:10am regarding the failure of nursing staff to contact Resident #3's first contact/resident representative after the 12/13/25 change in condition incident. RN #7 confirmed that he/she was the author of the change in condition document on 12/13/25. RN #7 revealed that he/she attempted to contact the 1st contact after the 12/13/25 change in condition incident. He/she stated that they were unable to reach the 1st contact and proceeded to contact the 2nd contact on the list. RN #7 also admitted that he/she did not leave a message when he/she attempted to contact the 1st contact. RN #7 also admitted that he/she failed to document the contact attempt. The surveyor informed the Executive Director and the Regional Nurse of the concern of RN #7 failing to document the attempt to contact the 1st contact after a change in condition.