

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>42782</p> <p>Based on staff interviews and observations, it was determined the facility staff failed to: 1) provide a resident with a locked cabinet to secure valuables, and 2) maintain residents' shower rooms to be operational, usable, and in good repair. This was evident in 1(#59) of 1 resident records reviewed for accommodation of needs during the survey and 6 out of 9 resident shower stalls observed during the survey.</p> <p>The findings include:</p> <p>1) On 01/10/24 at 10:05 am during an interview with Resident #59, he/she reported having money taken from his/her drawer a month prior and requested to have a lock on the bedside table. The surveyor checked the bedside table, and a lock was not in place.</p> <p>On 01/18/24 at 2:16 pm, the Administrator reported a Concern Form was completed in November 2023 and they spoke with the resident. He/she indicated she misplaced the money and didn't believe it was taken. A lock box with a key will be provided. Review of the Concern Form dated 11/01/23 revealed that maintenance would apply a lock to her stand/closet.</p> <p>On 01/23/24 at 10:52 am during an interview with Maintenance and EVS Director #24 he/she stated, if a resident wanted a lock, the request would come through TELS from the staff or the resident could tell him/her directly. He/she was out sick in November & December 2023. Upon return he/she was made aware the resident requested to have the lock. Maintenance Assistant #10 covered while he/she was out on leave.</p> <p>48167</p> <p>2) During an interview on 01/22/24 at 10:10 AM, staff (#29) expressed concerns about the showers in the facility. Staff (#29) stated that, because the 1st floor shower room's heating unit wasn't working, facility management staff told him/her to turn on showers #2 and #3 to heat up the room while using shower #1 to shower a resident. Staff (#29) also stated that the facility uses some of the resident shower stalls as storage and they could not shower the residents in them.</p> <p>During observation rounds of the facility on 01/22/24 at 11:12 AM with the Administrator and Staff (#9) of the facility's 1st, 2nd, and 3rd floors, it was found there that there was 1 resident shower room on each floor with 3 resident shower stalls to shower facility residents in each room. The following observations were found:</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>First floor resident shower room:</p> <p>a. The heating unit that provides heat to the shower room was broken and could not be used and there was cold air coming from the outside through the heating unit and its surroundings. After the surveyor's intervention the heating unit was replaced.</p> <p>b. Resident shower stall # 2 located on the right side of the room, had 2 wheelchairs and part of a Hoyer lift was stored in the shower stall.</p> <p>c. Resident shower stall #3 located on the right side of the room had no intact or visible shower head or hose attached to the shower piping located on the wall. Therefore, the shower was not able to be used by staff or residents.</p> <p>Second floor resident shower room:</p> <p>a. Resident shower stall # 2 located on the right side of the room, had no water handle hardware. Therefore, the water could not be turned on. There were 2 bedside commodes stacked on each other, a Hoyer lift and other medical equipment stored in the shower stall.</p> <p>b. Resident shower stall #3 located on the right side of the room and when the surveyor attempted to turn the water faucet on there was no running water coming out of the pipes therefore the shower was unable by staff or residents. There was an electric scooter and other medical equipment stored in the shower stall.</p> <p>Third floor resident shower room:</p> <p>a. Resident shower stall #2 located on the right side of the room had a Hoyer lift and other medical equipment stored in the shower stall.</p> <p>b. Resident shower stall #3 located on the right side of the room had no intact or in sight shower head or hose attached to the shower piping located on the wall therefore the shower was not able to be used by staff or residents.</p> <p>During an interview on 01/22/2024 at 11:45 AM, Staff (#9) stated that they would contact a plumber to come in and work on the water problems and fixtures in the resident's shower stalls.</p> <p>During an interview on 01/23/2024 at 12:30 PM the Administrator stated that the plumber was in the building and the facility was looking for a storage unit off site to place equipment that is being stored in the residents' shower stalls.</p> <p>During exit conference with facility on 01/26/2024 at 5:00 PM the above concerns were discussed with the administrative staff.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on observation and interviews it was determined that the facility staff failed to:1) maintain the residents rooms in a homelike environment, and 2) provide comfortable and safe temperatures in a common space used by and for residents. This deficient practice was evident in 1 of 3 clinical units, 2 out of 2 elevator cars observed during the survey.</p> <p>The findings include:</p> <p>1) During observation rounds on 01/09/24 at 9:40 am when the surveyor entered room [ROOM NUMBER], the surveyor observed the call bell system hanging from the wall. The surveyor observed marring on the wall behind Bed-1. Certified Medicine Aide # 37 confirmed the surveyor's findings.</p> <p>On 01/10/24 at 2:05 pm while in the bathroom of room [ROOM NUMBER], the surveyor observed the ceiling tile with a vent was buckled and the floor tile around the commode was dirty and discolored. GNA #38 confirmed the surveyor's findings.</p> <p>On 01/26/24 at 11:25 am the Director of Nursing reported every 2-3 hours the staff should visibly check on the residents. The call bell that was hanging out of the wall was repaired. They have the TELS system in Point Click Care and maintenance books on the units.</p> <p>On 01/26/24 at 11:37 am during an interview with Assistant Director of Nursing #1 who reported the staff are encouraged to use TELS system and the maintenance log has not been used since October 2023. The staff were educated several months ago to use TELS to put work orders and any type of maintenance issues.</p> <p>On 01/26/24 at 11:48 am during an interview with Maintenance Assistant #10, who stated, the call light was out of the wall, he/she is unsure if the work order was in TELS or he/she was told verbally and the entire box had to be changed.</p> <p>48167</p> <p>2) During observation rounds, on 01/18/2024 at 9:30 AM with the Administrator and Staff (#9) revealed that the temperature in both facility elevator cars was uncomfortably cold. Both elevator cars were used by facility staff to transport residents to other floors for rehabilitation services and other resident needs. Staff (#9) stated that there was an opening in the top level of the building, and they were working on closing the holes in the building to keep the elevators warm. Further observations during rounds revealed a large opening in the elevator shaft to the outdoors at the top of the facility building and approximately 1 to 2 inches of water on floor of lowest level of the elevator shaft. Staff (#9) stated that the facility was looking into getting sump pumps to remove any standing water that may accumulate. Staff (#9) took elevator temperatures using a digital infrared thermometer gun in both elevators during observation rounds and both elevator cars were found to be between 50 - 51 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/25/2024 at approximately 10:00 AM the Administrator stated that the facility was still working on addressing the elevators' temperature, water collection on lowest level of the elevator shaft and the corporate office was discussing different options to correct these issues.</p> <p>During the exit conference with the facility staff, on 01/26/2024 at 5:00 PM, the above described conditions and concerns were discussed with the administrative staff.</p> <p>30440</p> <p>3) An observation was made on 1/18/24 at 11:00 AM of a resident room during an interview with the resident to discuss concerns. Resident #141 stated that a mouse was seen in the room and that the mouse retreated in a hole that is in the wall behind the toilet.</p> <p>At that time an observation was made of the bathroom and there was a hole in the wall next to the toilet and above the base board. It was approximately the size of 3 silver dollars.</p> <p>Review of the maintenance logs that were provided to the survey team indicated that the building was treated on 1/5/24 by a pest control company for mouse complaints on the first floor.</p> <p>An interview was conducted with the Maintenance Director on 1/18/24 at 3:40 PM and he was made aware of the resident concern regarding the mice and the observation of the hole in the resident bathroom and he stated that he would repair the hole. The Maintenance Director returned to the survey team on 1/19/24 and reported that the hole in the resident room was repaired. He also stated that the pest control service will be returning to treat the mice concerns.</p> <p>The administration team was made aware of all concerns at the time of exit on 1/26/24 at 5:05 PM.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<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>42782</p> <p>Based on record review and interview it was determined that the facility failed to protect a resident from verbal abuse. This deficient practice was evident in 1 (#241) of 4 facility reported incidents investigated during the survey.</p> <p>The findings include:</p> <p>On 01/24/24 at 2:50 pm a review of the facility's investigation of MD00184620 revealed that on 10/11/22 while providing personal care to Resident # 241 the Geriatric Nursing Assistant (GNA) #49 yelled at and spoke to Resident #241 in a demeaning manner according to the resident's roommate.</p> <p>On 01/24/24 at 3:24 pm further review of the investigation revealed Resident # 241's roommate reported the GNA #49 was verbally abusive to the resident. The alleged GNA was interviewed. A complaint was filed with the Maryland Board of Nursing (MBON) on 10/18/22.</p> <p>Review of the five-day follow-up report submitted by the facility indicated the allegation of abuse was not substantiated. On 01/26/24 at 12:38 pm the surveyor asked the Director of Nursing why abuse was not substantiated when GNA #49 was terminated on 10/18/22 and reported to the MBON for verbal abuse. 01/26/24 at 1:12 pm the Administrator verbalized, after review of the investigation he/she realized an error was made and the result of the investigation should have said the allegation was substantiated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>30440</p> <p>Based on administrative record review and interviews with facility staff it was determined the facility failed to report allegations of abuse to the state agency within the two hour timeframe. This was found to be evident for 4 of 22 facility reported abuse investigations reviewed during the facility's survey.</p> <p>Findings include:</p> <p>1) While the survey team was conducting the survey, the facility administration team was informed on 1/17/24 at 2:19 PM of an allegation of abuse by residents regarding a staff member. The facility stated to the survey team that they would investigate.</p> <p>A meeting was conducted with the Administration team on 1/22/24 at 10:30 AM and they gave an update to the survey team. The Administrator was asked if the facility sent an initial report to the state agency and he stated that after conducting their investigation, abuse was unsubstantiated and that it was a customer service concern provided education to the staff. The Administrator returned to the survey team on 1/23/24 and stated that he submitted a late initial report to the state agency and will follow-up by sending the required 5-day final report.</p> <p>All concerns were discussed with the administrative team at the time of exit on 1/26/24 at 5:05 PM.</p> <p>42782</p> <p>2) While speaking with Resident #52 on 01/10/24 at 2:12 pm the surveyor asked the resident if he/she had any concerns. Resident #52 reported having a verbal confrontation with a GNA and the GNA cursed at him. Also, he/she asked the nurse to have the room cleaned after a resident with COVID was removed. The nurse allegedly refused and kept telling the resident, he/she had something for him/her and he/she felt threatened by the nurse.</p> <p>On 01/12/24 at 4:26 pm the surveyor asked the Director of Nursing if there was a self-report for abuse concerning Resident #52.</p> <p>On 01/17/24 at 2:21 pm the Director of Nursing reported the facility did not have a self-report for Resident #52. The surveyor made the Director of Nursing and Administrator aware of the alleged allegation of abuse concerning Resident #52.</p> <p>On 01/18/24 02:11 pm interview with the DON revealed the alleged staff members were suspended pending investigation.</p> <p>On 01/25/24 at 3:08 pm a review of the initial report and 5-day follow-up revealed the initial self-report regarding abuse allegation was not reported to the state agency within the 2-hour allotted time frame.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/26/24 at 11:00 am during an interview with the Director of Nursing, he/she stated, the abuse case was reported late, that they have an abuse policy, and they are familiar with the policy.</p> <p>45733</p> <p>3) Record review on 01/23/24 at 2:45 PM, of the facility's self-report investigation file revealed that the Director of Nursing (DoN) documented on the Facility's Incident Investigation Form that the incident occurred on 06/29/23 at 11:50 AM (page 1 of 5). The facility's initial self-report was sent to the State agency on 6/29/23 at 2:53 PM, more than 3 hours later.</p> <p>During the interview, on 01/23/23 at 3:02 PM, the Regional Nurse staff #3 confirmed that the initial self-report for this abuse allegation had not been sent within 2 hours.</p> <p>4) Review on 01/24/24 at 01:35 PM, of the facility's self-report investigation file revealed that the Director of Nursing (DoN) documented on the Facility's Incident Investigation Form the incident time was on 06/21/22 at 12:30 PM (page 1 of 5). GNA staff #47 allegedly hit Resident #97's head while providing care.</p> <p>Based on the allegation of abuse/harm, the facility's self-report had to be sent to the State agency no later than 2 hours after the incident had occurred or was reported. Further review revealed that staff had sent the facility self-report to the State agency, on 06/21/22 at 7:50 PM, 7 hours and 20 minutes after the incident.</p> <p>During the interview on 1/25/24 at 12:50 PM, the DoN, the Administrator, and the Regional Administrator Staff #4, confirmed that facility staff was made aware of the abuse allegation on 06/21/22 at 12:30 PM, however, the initial self-report was not sent to the State agency until 6/21/22 at 7:50 PM.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>42782</p> <p>Based on record review and interview it was determined that the facility staff failed to send a copy of a resident's transfer to the hospital to the Ombudsman. This deficient practice was evident in 1 (#20) of 2 resident records reviewed for transfer/discharge paperwork during the survey.</p> <p>The findings include:</p> <p>On 01/10/24 at 11:34 am, a review of Resident #20's electronic medical record revealed the resident was transferred to the emergency department on 10/20/23.</p> <p>On 01/23/24 at 3:04 pm the surveyor requested a copy of the resident's transfer notice sent to the responsible party and verification a copy was sent to the ombudsman.</p> <p>On 01/24/24 at 9:32 am the surveyor received a copy of the October 2023 admission/discharge list that was emailed to the ombudsman on 11/01/23 at 7:12 am. Resident #20 was not included on the list.</p> <p>On 01/24/24 at 10:41 am during an interview with Regional Nursing Director #3 who verbalized the staff did not do the quick editing and when the Administrator pulled the report, Resident #20 was not on the list which was realized on 1/23/24.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42782</p> <p>Based on medical record review and interview it was determined that the facility staff failed to: 1) initiate a patient centered care plan for a resident who was ordered oxygen therapy, 2) initiate a care plan for a resident who had a significant weight loss, and 3) establish a care plan specific to one of the resident's primary diagnosis. This deficient practice was evident in 3 (#20, #32, #12) out of 6 resident records reviewed for the initiation of care plans for residents.</p> <p>The findings include:</p> <p>1) On 01/17/24 A review of Resident #20's electronic medical record revealed the resident had an order for oxygen therapy. Further review of the EMR revealed the resident did not have a patient specific care plan for oxygen therapy.</p> <p>On 01/17/24 at 12:38 PM during an interview with Director of Nursing #1, If a resident has a diagnosis indicating the need oxygen he/she would put the care plan under respiratory or cardiac depending on the resident's needs. DON #1 confirmed Resident #20 did not have a patient specific care plan for oxygen therapy.</p> <p>2) On 01/17/24 at 11:30 am a review of Resident #32's electronic medical record revealed that the resident did not have a care plan for weight loss despite having a significant weight loss.</p> <p>On 01/17/24 at 12:50 pm during an interview with the Director of Nursing, when asked if Resident #32 had a care plan for weight loss, he/she verbalized the resident did not have a care plan for weight loss.</p> <p>On 01/17/24 at 1:17 pm during an interview with Dietician #21 he/she reported he/she typically does not care plan for weight loss.</p> <p>42863</p> <p>3) On 01/10/24 11:34 AM, the surveyor interviewed Resident #12 who stated he/she was unable to recall the last time a care plan meeting was held with the facility staff.</p> <p>A review of the electronic medical record on 1/11/24 at 10:30 AM revealed that the social worker # 7 described Resident #12 as displaying impaired memory and poor problem solving and insight per the results of the resident's Brief Cognitive Assessment Tool (BCAT) documented on 1/4/2024. Further review of the resident's care plan on the same day failed to reveal a care plan specifically addressing the resident's diagnosis of dementia.</p> <p>On 01/22/24 at 01:29 PM a record review was performed by surveyor and no dementia care plan was documented in the electronic medical record. Additionally, the surveyor received a copy of the care plan meeting held in the resident's room with the resident's son participating by telephone on 1/4/2024. The resident's dementia was not addressed during the care plan discussion per the written care plan meeting notes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the director of nursing (DON) and the social worker # 7 confirmed that the interdisciplinary team had not created a dementia care plan for Resident #12 as of 1/22/24 at 1:30 PM.</p> <p>The concern that the facility failed to create, and to implement a comprehensive dementia care plan that addressed the resident's specific physical, social, and psychological needs was addressed with the DON, two regional RNs, and the administrator during the exit conference on 1/26/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to: 1) update a resident care plan to address the resident specific needs (Resident #63), 2) have quarterly care plan meetings including the dietician for a resident who had a significant weight loss (Resident #89), 3) initiate a diagnosis specific care plan for a resident during the resident's length of stay (Resident #12). This was found to be evident for 3 of 62 residents, reviewed for care plan timing.</p> <p>Findings include:</p> <p>1) During an observation made on 1/10/24 at 12:10 PM, Resident #63 was observed lying in the bed and the resident was noted to have lesions present to the right neck area near the ear and left ear area. The area had redness with a small amount of heme (blood) present. A staff nurse who was present at the nurse station was made aware of the observation and she stated that she would assess the resident.</p> <p>Resident #63's medical record was reviewed on 1/23/24 at 11:30 AM and upon review it revealed the resident had a care plan in place for impaired skin integrity of Right Neck and Left ear. The care plan was created on 12/8/23 with a revision date of 1/10/24.</p> <p>During an interview with the Director of Nursing (DON) on 1/24/24 at 9:30 AM she was asked to provide the survey team with a copy of any recent Dermatology and/or ENT (Ear, Nose and Throat) Consultations. The DON returned to the survey team on the same date at 3:00 PM and provided a copy of the resident Dermatology and Plastics Consultation scheduled for 2/1/2024. The form indicated an order date of 1/24/24 at 14:39. The DON informed the survey team that the resident was diagnosed with Squamous Cell Carcinoma (Skin Cancer) on 1/8/2024. The DON was asked if the resident had a care plan in place for Squamous Cell Carcinoma when diagnosed on [DATE] and she stated no, but she would update the resident care plan to address the resident specific needs to include consultations as needed.</p> <p>The Administration team was made aware of all concerns at the time of exit on 1/26/24 at 5:05 PM.</p> <p>42782</p> <p>2) On 01/16/24 at 10:45 am review of Resident #89's electronic medical record revealed a care plan meeting was held on 09/21/23. The previously held care plan meetings were on 4/20/23 and 8/5/2022.</p> <p>On 01/16/24 at 12:20 pm the surveyor requested a copy of the care plan sign in sheet for 09/21/23.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/17/24 at 12:09 pm during an interview with Director of Social Services #5 verbalized a list of residents who needed a care plan meeting is obtained from the MDS coordinator. Short term resident meetings are usually held on Tuesdays and long-term resident meetings are held on Thursdays depending on the availability of the resident and family. Arrangements are made about a week in advance. The interdisciplinary team which includes nursing, Activities, the Dietician, therapy, the resident, and family. A sign-in sheet is created, and a note will be entered into PCC as the interdisciplinary team talks about changes with the team and possibly the physician. The resident is provided a copy of the meeting date, and the letter explains what a care plan meeting is. Care plan meetings are done upon admission, quarterly, and with a significant change. When asked why the resident did not have quarterly care plan meetings, Director of Social Services #5 was unable answer the surveyor's question.</p> <p>On 01/17/24 at 1:31 pm the surveyor received a copy of the care plan meeting note and the sign in sheet for the 9/21/2023 care plan meeting. The Director of Social Services #5, someone from nursing, and Resident #89 significant other attended the meeting.</p> <p>On 01/17/24 at 2:07 pm during an interview with Dietician #21 who verbalized he/she does not know why he/she didn't attend the care plan meeting in September 2023. He/she was not sure if they were in the building but the social worker had access to his/her notes.</p> <p>42863</p> <p>3) On 1/23/24 at approximately 3:45 PM the surveyor reviewed the Diagnosis Report provided by the DON. This report listed all residents currently in the facility with a diagnosis of dementia. There were a total of 38 residents with the diagnosis of dementia and Resident #12 was listed on the report. Resident #12 was listed as having an admitted [DATE]. The surveyor asked the DON whether the expectation would be that a dementia care plan should have been created for Resident #12 and the response was 'Yes.</p> <p>On 01/22/24 at 11:54 AM during an interview with social worker #7, the surveyor asked whether the Resident #12 had a dementia care plan and the response was No. Social worker #7 also stated that there had not been any interventions related to dementia discussed with the resident or family members.</p> <p>On 1/22/24 at 11:30 AM the surveyor reviewed the Resident #12's care plans located in the electronic medical record and determined no care plan was initiated after admission for the diagnosis of dementia.</p> <p>On 01/22/24 at 11:00 AM an interview with staff 4, activities director stated that there was no specific dementia related activities program at the facility. Also, staff # 4 stated that he/she has not provided Resident #12 any dementia focused activities.</p> <p>The concern that the facility failed to initiate a dementia care plan for Resident #12 was discussed with the DON and the administrator on 1/26/24 during the exit conference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on record review and interviews it was determined that the facility staff failed to provide a summary of a resident's stay and a copy of the most recent comprehensive assessment to a resident who initiated a discharge. This deficient practice was evident in 1 (#241) of 1 resident-initiated discharge record reviewed.</p> <p>The findings include:</p> <p>On 01/25/24 at 10:14 am a review of Resident #241's electronic medical record (EMR) revealed the resident was discharged on [DATE].</p> <p>On 01/25/24 at 11:01 am during an interview with Director of Social Services #5 revealed the resident initiated the discharge so arrangements were made after gathering information with the resident for needs at home and process is to provide discharge instructions, prescriptions and a medication list.</p> <p>On 01/25/24 at 11:05 am the surveyor requested to view Resident #241's discharge instructions, post discharge plan of care, and all the documents provided to Resident #241 when discharged .</p> <p>On 01/25/24 at 11:40 am the surveyor reviewed Resident #241's post discharge plan of care, 17 prescriptions, and a note dated 06/30/23 which was included in the care area. A summary of the resident's stay at the facility and a comprehensive assessment was not included in the documentation provided to the resident upon discharge.</p> <p>On 01/25/24 at 1:27 pm during an interview with Director of Social Service #5 when the surveyor asked if the resident was provided a summary of his/her stay at the facility and a copy of their most recent comprehensive assessment, Director of Social Services #5 verbalized he/she does not have that information but could get that information from the hospital. The post discharge plan of care and prescriptions was prepared in a discharge folder for the nurses to go over with Resident #241 before they leave.</p> <p>On 01/25/24 at 3:12 pm during an interview with the Director of Nursing who verbalized if a resident says they want to go home they find out why. Resources in the community are provided, the discharge documentation is provided by the nurses. The post discharge plan of care, a list of medications and prescriptions, an AMA form if indicated are also provided and the nurse is expected to write a note. Included in the note is where the resident is going and who they are going with.</p> <p>On 01/25 24 at 4:15 pm a review the discharge note written by the nurse who discharged Resident #241 wrote the time the resident was picked up and by whom, the resident left with all medications in cart with wheelchair and walker, all belongings went with the resident, all paperwork needed was signed and scripts faxed to pharmacy. There was no documentation to support the resident received a copy of his/her most recent comprehensive assessment or a summary of his/her stay within the facility.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863</p> <p>Based on medical record reviews, observations, and interviews it was determined that the facility failed to ensure that residents requiring assistance with activities of daily living (ADL's) such as bathing and/or showering were provided these services. This was found to be true for 3 of 3 residents (#32, #38, and #82) reviewed for activities of daily living.</p> <p>The findings include:</p> <p>1. On 1/22/24 at 10:12 AM the surveyor toured three clinical units in the facility. The surveyor was informed by the administrator that there were three single occupancy resident rooms with private showers. The surveyor observed that the bathroom in room [ROOM NUMBER] did not have a shower curtain and there was storage of a wheelchair, and walker inside the shower stall. Resident #82 was present in his/her bed watching the TV, dressed in civilian clothes.</p> <p>At approximately 10:15 AM on 1/23/24 the surveyor interviewed Resident #82 who stated that he/she had not been provided a shower since his admission, but the staff had assisted him with getting washed up. The surveyor asked the resident what his/her preference and he/she stated that he/she preferred having a shower and loves to shower every day. The surveyor reviewed the resident's Kardex which listed the resident's weekly schedule for showers was on Tuesday and Thursdays on the 3-11 PM shift.</p> <p>2. On 1/24/23 at 2:45 PM the surveyor interviewed Resident #32 who stated that he/she usually receives assistance with a shower one time per week but is supposed to get a shower twice a week.</p> <p>On 1/25/24 at 14:30 PM the surveyor reviewed the Documentation Survey Record for the following residents:</p> <p>a. Resident # 32's personal hygiene/shower PCC form showed that he/she was not helped with personal hygiene on 12/12/23 on the 3-11 shift (the space was left blank), and on 12/19/23 on the evening shift, the entry space was left blank. 12/26/24 the documentation space on the 7-3 shift entry was 09 which equals to not applicable per the legend listed on PCC form.</p> <p>b. On 12/26/23 for Resident #32 the shower/tub bath box, the day shift entry documentation slot was left blank. The slot for personal hygiene dated 12/30/23, 3-11 shift left blank. Also, the personal hygiene data entry field for 1/19/24, 3-11 shift was left blank as well as the entry box for showers on the 3-11 shift for the same date was left empty as well.</p> <p>c. Resident # 82's personal hygiene/shower PCC (Point Click Care) form showed that he/she was not provided either personal hygiene and/or a shower/tub bath on 12/24/23 and 12/25/23 on either the day or evening shift. Resident # 82's personal hygiene/shower PCC form 12/25/23 and 12/26/23 had entries in the 7-3 and 3-11shift shower entry space of not applicable and on 12/28/23 on the day shift for the shower section.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident # 38's personal hygiene/shower PCC form showed that on 1/2/24 the staff did not enter any data whether the resident was assisted with personal hygiene on dayshift. Additionally, on 1/2/24 the data entry field for shower/tub bath was blank for day shift and entered the evening shift space was marked as not applicable.</p> <p>An interview with the level 2-unit manager, staff# 31 on 01/24/24 at 2:46 PM revealed that documentation of residents' shower schedule entered onto handwritten shower logs and include the resident preferences. Staff #31 stated that the shower log listed which residents had received and or refused a shower on a specific date and time. Also, that the GNAs document in the electronic medical record whether resident does or not receive a bed bath and/or a shower. The GNAs are expected to inform the LPN or RN of any resident refusals during the shift.</p> <p>On 1/24/24 at approximately 3:15 PM the surveyor interview was held the DON and staff #5 regarding the documentation of the provision of assistance with showering and/or bathing for residents. Staff #5 stated that the staff use a hard copy document that reflects whether a resident refused to bathe or shower, and that form is kept at the nurses' station. Also, staff #5 stated that the geriatric nursing assistants (GNAs) document in the electronic medical record during day and evening shifts.</p> <p>During an interview on 1/24/24 at 09:05 AM, the surveyor requested that staff #5 provide a copy of the facility's ADL policy.</p> <p>During an interview on 1/25/24 at 2:54 PM staff # 3 stated that there was some confusion regarding whether the shower rooms were available on 1/23/24 which explained why some residents did not receive scheduled showers. Also, staff # 3 stated that the GNAs have the option to take the residents to other floors to ensure showers are provided to residents. Also, staff # 3 was asked by the surveyor what was the expectation for the GNA staff to document refusal to ADL care. Staff # 3 stated that if the resident is refusing to shower then that information is triggered in PCC. Also, staff # 3 showed the surveyor where in PCC the GNAs document whether the resident refused or received a shower.</p> <p>On 1/26/24 at approximately 11:10 AM the surveyor requested the DON to provide a copy of the facility's ADL policy. At approximately, 3:20 PM staff # 5 informed the surveyor that the facility did not have an all-inclusive ADL policy but had 5 individual policies that addressed skin preventative care, nail care, passive range of motion, oral hygiene, tepid sponge bath, and shaving a resident.</p> <p>The concern that the facility failed to consistently provide personal hygiene and /or showers to three residents based on the documentation was reviewed with the administrator, Staff #5 during the exit interview on 1/26/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733</p> <p>Based on medical record review, observation and interview, the facility staff failed to prevent new pressure ulcers/in-house acquired wounds from occurring. This was evident for 2 (Resident #242 and #92) out of 3 residents reviewed for new pressure ulcers during the survey.</p> <p>The findings include:</p> <p>A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved prolonged pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and /or eschar in the wound bed).</p> <p>1). Record review, on 01/25/24 at 11:50 AM, revealed Resident #242 was readmitted to the facility on [DATE] with major diagnosis of an old Stroke with left side hemiplegia. Reviewing the admission nursing assessment revealed this resident's skin was intact. (A Stroke occurs when blood flow to part of your brain is blocked or when a blood vessel in the brain ruptures. When this happens, the brain cells in the affected area are deprived of oxygen or damaged. A left sided stroke affects the right side of a person's body.)</p> <p>Further record review on 1/25/24 of complaint MD00185884 alleged that Resident #242 was not admitted to the facility with pressure ulcers but had developed after admission with allegations regarding being left in urine and not turned and re-positioned every 2 hours.</p> <p>Record review, on 1/25/24, of the Wound Physician Staff #30's initial evaluation and summary dated 11/28/22, revealed two new wounds:</p> <p>1. on 11/23/22, a left heel wound measuring 2.0 x 1.5 centimeters and</p> <p>2. on 11/28/22, a right upper buttock deep tissue injury (DTI) measuring 4.0 x 2.0 centimeters. A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise.</p> <p>During the interview, on 1/26/24 at 9:12 AM, the Director of Nursing (DoN) stated that the resident did not have the right buttock pressure wound upon readmission on 10/28/22.</p> <p>2). On 01/10/24 at 02:09 PM, the surveyor was touring the unit, Resident #92 reported I have a new wound on my buttock, and I was sore staying in one position.</p> <p>On 01/16/24 at 11:45 AM, review of Resident #92's record revealed admission on 10/5/2023 with the major diagnoses of Chronic Respiratory Failure and Incontinence of Bowel and Bladder. The resident was identified as a pressure ulcer risk per facility's assessment 10/6/23.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the skin and wound record on 1/16/24 revealed a new open wound on 12/4/23 at 15:32 PM by the Unit Manager Staff #31's documentation. The size of the open left lower buttock's wound was 1.0 x 1.0 x 0.2 centimeters.</p> <p>On 01/17/24 at 01:14 PM, during an interview, Staff #31 confirmed the left buttock wound developed while the resident was residing in the facility. Staff #31 stated that this resident often refused to be turned. However, Staff #31 could not provide any documentation to show this resident refused to be turned prior to when the wound developed. The DoN was made aware of the concern.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>30440</p> <p>Based on administrative record review and interviews with facility staff it was determined the facility failed to: 1) ensure annual staff performance reviews were completed as required, 2) ensure an annual performance review for the facility Geriatric Nurse Aides (GNAs), 3) provide performance related outcomes based staff education. This was found to be evident for 1 of 7 clinical employee files reviewed and for 1 of 5 GNA's that were reviewed during the survey.</p> <p>Findings include:</p> <p>On 1/26/24 at 2:00 PM two employee files were reviewed after Resident #143 reported allegations of abuse to the facility staff on 1/24/24. Upon review of the employee file for Licensed Practical Nurse (LPN) #43 who was hired in 2021 did not contain documentation of a performance evaluation. Further review of LPN #43's file revealed a documented disciplinary notice dated 11/15/22 with an (x) documented next to written warning, for not following proper infection control procedures.</p> <p>On 1/4/23 LPN # 43 did not complete schedule evaluations for a shift and on 1/5/23 she did not complete lab report documentation as instructed by supervisor. There was a check mark in the box indicating verbal counseling. There was a disciplinary notice form dated 11/15/23 which indicated LPN # 43 was insubordinate to the Nurse Practitioner regarding care of a resident and communication with supervisor. There was an (x) marked in the box on the form next to written and next to final written warning.</p> <p>An interview was conducted with the Director of Nursing (DON) and the Regional Nurse (RN) Staff # 3 on 1/26/24 at 3:00 PM and they both stated that the annual performance evaluation should have been completed and confirmed that if the evaluation was not in the employee file, that it was not done. They stated that it is the facility's goal for 2024 is to complete all employee's annual performance evaluations.</p> <p>All concerns regarding annual performance reviews and any training for identified problems were discussed with the administration team at the time of exit on 1/26/24 at 5:05 PM.</p> <p>49304</p> <p>2) On 1/22/2024 at 2:30 PM, the employee files of five GNA's were reviewed. During the review, no performance evaluation could be found that had been performed for GNA #7 of the 5 GNA's reviewed in the 2023 calendar year.</p> <p>On 1/24/24 at 1:40 PM, in an interview with the Administrator , he provided documentation that GNA #7 began working in the capacity of GNA in Training on 6/28/23 and continues to work in that capacity currently.</p> <p>On 01/25/24 at 12:48 PM, in an interview with the Director of Nursing (DON), she stated if employee performance evaluations are not in the employee's file, then they have not been completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/26/24 at 11:36 AM, the DON stated she did not think GNA #7 had an annual performance review and that she should have completed one after three months.</p> <p>On 1/26/24 at 12:40 PM, the DON left a note for the survey team stating they GNA #7 did not have an Annual Performance Review.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48167</p> <p>Based on observations, interviews and review of facility documentation the facility failed to properly store medications and biologicals under proper temperature controls according to professional standards. This was evident in 1 out of 3 medication storage refrigerators observed during the survey.</p> <p>The findings include:</p> <p>During observation rounds of the facility 2nd floor medication storage room on 01/12/24 at 11:37 AM with Staff (#3) the refrigerator storing medications and biologicals thermometer read 58 degrees F. Several medications and biologicals for facility residents were found in this refrigerator.</p> <p>During an interview on 01/12/24 at 11:50 AM Staff (#3) stated that yes, the refrigerator was too hot and confirmed that the refrigerator thermometer read 58 degrees F. Staff (#3) stated that he/she will get someone to come now to fix it.</p> <p>Review of facility policy for Medication Storage on 01/12/24 at 3:30 PM revealed that medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are to be kept in a secure refrigerator with a thermometer to allow temperature monitoring.</p> <p>During the exit conference with facility on 01/26/2024 at 5:00 PM the above concerns were discussed with the administrative staff.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733</p> <p>Based on interview, observation and record review, it was determined that the facility failed to follow a resident's food intolerance list and to honor requested double-portion meals. This was evident for 1 (Resident #391) out of 9 residents reviewed for food preference and nutritional adequacy.</p> <p>The findings include:</p> <p>On 1/9/23 at 10:28 AM, the surveyor interviewed Resident #391 who stated I could not do too much .too weak and needed to re-strengthen. I was hungry and told the staff that I need .more food on my tray, like a doubled portion. This resident was observed in bed with a 30 degrees up sitting position. Visibly excessive nasal and neck muscles were being used to gain air intake from his/her oxygen supply.</p> <p>During record review on 1/11/24 at 13:19 PM, it was revealed that Resident #391 was admitted to the facility on [DATE] after an intensive care hospitalization . The resident had a history of gastro-esophageal reflux disease (GERD). Gastroesophageal reflux disease (GERD) is a common condition in which the stomach contents move up into the esophagus. Reflux becomes a disease when it causes frequent or severe symptoms or injury. Reflux may damage the esophagus, pharynx or respiratory tract.</p> <p>On 1/11/24 at 13:19 AM, record review revealed that Resident #391 was seen on 1/8/24 by the Speech Therapist Staff #48 that the resident complained to her I was still receiving orange juice and acidic foods (despite the food service communication form being filled out on 1/4/24) that such food/drinks should not be served. staff #48 entered an order on the same day to the Dietician Staff #21 for additional interventions.</p> <p>Further observation, on 1/12/24 at 11:45 AM, revealed that the resident was telling the staff who delivered his/her meal tray I need a larger portion of food today and I do not like snacks. During an interview with Staff #21 at that time, regarding the resident's concerns, Staff #21 stated she had the resident assessed and had the intolerance list and food portions set up in the system.</p> <p>On 1/16/24 at 09:05 AM Resident #391 continued to report I need more food each meal to help me to gain weight and strength. An interview with Kitchen Manager Staff #39 right afterwards revealed that the facility only allowed larger proportion meals if the order had to be coming from this resident's Attending Physician.</p> <p>Record review, on 1/16/24 at 1:30 PM, revealed this resident was on a modified diet: National Dysphagia Diet 3 (NDD3) and advanced to regular texture trial on 1/14/23 so that he/she could have more food intake.</p> <p>Additional complaints received on 1/11/24 per Staff #48 Pt. expressed numerous other dietary concerns/preferences and on 1/16/24 continued receiving items that can aggravate his/her ulcer. The clinician emailed the dietician and kitchen manager requesting another consult. A level 3 National Dysphagia Diet includes moist foods in bite-sized pieces.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additional observation, on 1/17/24 at 1:15 PM, revealed that this resident received broccoli and berries. During an interview, on 1/17/24 at 2:20 PM, Staff #21 did not provide any improvement documentation in regard to Resident #391's multiple food complaints in the last 8 days. The Kitchen Manager Staff #39 and the DoN were made aware.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45733</p> <p>Based on observation and interview regarding the facility kitchen's operation, it was determined that the facility failed to store food in accordance with professional standards for food service to prevent the potential for contamination. This was evident for 2 out of 3 observations in the kitchen.</p> <p>The findings include:</p> <p>On 1/9/24 at 10:31 AM, a tour was conducted in the kitchen with Regional Kitchen Director Staff #13. The surveyor observed and pointed out that there was a bucket sitting on the floor with labeled food items and dates.</p> <p>Further observation, on 1/22/24 at 10:00 AM, revealed that a stack of fresh bread in eight large trays was sitting on the kitchen floor in the middle of a high foot traffic area. The last tray was only less than one inch from touching the floor.</p> <p>During interview, Kitchen Director Staff #39 stated that she was about to move the bread.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42782</p> <p>Based on medical record review, observations, and interview it was determined that the facility staff failed to: 1) consistently document whether a resident was having psychotropic medication side effects or behaviors. This deficient practice was evidenced in 1 (Resident #32) of 3 Behavioral Records reviewed during the survey; and 2) document in the progress notes, the consent of the resident or the resident representation prior to the installation of the side rails. This was evident for 3 out of 3 residents, (#2, #28, and #80) reviewed for siderail consent.</p> <p>The findings include:</p> <p>1) On 01/12/24 on 12:15 pm Review of Resident #32's Behavioral Record for November 2023 there was no documentation on the behavioral record on 11/18/23 and 11/19/23 during day shift for signs and symptoms of depression, inappropriate behaviors towards female staff, or psychotropic medication side effects. In December 2023 there is no documentation on 12/04/23, 12/09/23, and 12/14/23 for behavioral monitoring for signs and symptoms of depression, inappropriate behaviors towards female staff, or psychotropic medication side effects. In January 2024 on 01/03/24, 01/05/24, and 01/08/24 there was no documentation for behavioral monitoring for signs and symptoms of depression, inappropriate behaviors towards female staff, or psychotropic medication side effects.</p> <p>On 01/12/24 at 4:21 pm the surveyor and Director of Nursing reviewed Resident #32's Behavioral Record simultaneously and the DON confirmed the documentation was not completed on the days mentioned. During an interview with the Director of Nursing, he/she made the surveyor aware the nursing team reviews the orders and she makes sure the orders are carried out and the leadership team meets in the morning and afternoon to double back to see if the nurses forget to document.</p> <p>42863</p> <p>2) On 01/23/24 at 03:07 PM the surveyor interviewed staff #5 and the director of nursing (DON) regarding the siderail assessment, installation, and consent process. Also, the surveyor requested that staff # 5 provide a copy of the siderail assessment and the siderail consent form for three residents, #2, #28, and #80.</p> <p>On 1/24/24 at approximately 09:45 AM during an interview with staff #5 there was confirmation that the clinical staff are expected to document in the progress note, the date and time the side rail consent was obtained. However, the side rail assessment was completed by the DON on 1/16/24 for Resident #28. The DON and staff #5 stated the facility does not have a separate consent form for the resident or the resident representative to sign regarding side rails.</p> <p>On 1/24/24 at approximately 11:45 AM the DON provided the surveyor with a hard copy of the side rail assessment for Residents #28 and # 80. During an interview with DON the surveyor asked why three residents on the same day had orders for side rails installation for mobility without evaluations by the physical therapy and/or occupational therapy departments. The DON responded that she was not sure.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the electronic medical records on 1/25/24 at 09:30 AM the surveyor determined that there was no documentation in the electronic medical record related to the resident or resident representative consent being obtained prior to the installation of the side rails for Residents #2, #28, or #80.</p> <p>On 1/26/24 at 10:45 AM, the surveyor reviewed the hard copy progress note for Resident # 28 which documented a late entry progress note dated 1/18/24 at 17:01 PM, stated Resident #28 consented to bilateral grab handles for bed mobility. The siderail assessment and installation was documented as occurring on 1/16/24 at 21:37 PM.</p> <p>On 1/26/24 at 11:10 AM, the surveyor reviewed the late entry note progress note for Resident # 2 which was dated 1/24/24 at 11:05 AM and signed by staff # 3. Resident #2's late entry progress note read: on 1/17/24 resident spouse consented for resident to have 1/4 bedside rails for resident bed mobility. The assessment and installation of resident # 2's siderails occurred on 1/16/24 at 21:37.</p> <p>On 1/26/24 at 11:15 AM the surveyor reviewed the order summary (TAR) form for Resident # 80. The order date for the 1/4 siderails secondary to assist in bed mobility was 1/17/24. However, the siderail assessment and installation occurred on 1/16/24. The late entry progress note dated 1/23/24 at 20:55 for 1/16/24 at 8:54 PM stated, Resident #80 consented for the use of bilateral 1/4 bedside rails. He/she verbalized that he/she uses the rails to assist with bed mobility while receiving care from staff and was signed by staff #3.</p> <p>The surveyor reviewed the Bed Rails: Use of Corporation policy provided by the DON on 1/25/24 which stated that: 1. Residents will be assessed prior to the implementation of bedrails/assist handles as enablers to increase residents' functional ability. Line #4. If bed rails /assist handles are assessed as an enabler and not a restraint, consent for use shall be obtained from the resident/healthcare decision maker and documented in the clinical record.</p> <p>The concern for the timing of the bed rail consents and assessment/installation of bed was was discussed with the administrative staff prior to and during the exit conference on 1/26/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on observation and interview it was determined that the facility staff failed to maintain infection control practices as evidenced by a resident's oxygen tubing being uncovered and draped over the oxygen concentrator and five used, unlabeled, and undated urinals being left in the bathroom cabinet. The deficient practice had the potential to affect Resident #20 and the residents who reside in room [ROOM NUMBER].</p> <p>The findings include:</p> <p>During observation rounds on Unit 1 on 01/09/24 at 9:32 am, while in Resident #20's room the surveyor observed the resident's oxygen tubing draped over the oxygen concentrator. Under further inspection the surveyor noted the oxygen tubing was not labeled or dated. The sterile water connected to the oxygen concentrator was not labeled or dated. Geriatric Nursing Assistance (GNA) #7 was in the resident's room and confirmed the surveyor's findings.</p> <p>On 01/10/24 at 2:05 pm while in room [ROOM NUMBER]'s bathroom, the surveyor observed five used urinals under the bathroom sink. GNA #38 confirmed the surveyor's findings.</p> <p>On 01/23/24 at 11:54 am during an interview with the Director of Nursing he/she stated, the expectation is for a urinal to have the resident's room number, bed, and the date it was provided. The urinals are changed when visibly soiled and the same for bed pans. The oxygen tubing should have been dated, along with the sterile water and the tubing is usually changed weekly or when soiled. The resident's oxygen was ordered as needed.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Future Care Charles Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>30440</p> <p>Based on observations and interviews of facility staff it was determined the facility failed to ensure an effective pest control as flying gnats were observed throughout the building. This was found to be evident during the survey.</p> <p>Findings include:</p> <p>During the survey multiple observations were made of gnat sightings throughout the building. On the first day of the survey on January 9, 2024, surveyors were placed in one of the facility's rooms and with multiple flying gnats observed in the room.</p> <p>During a resident council meeting conducted on 1/11/24 at 10:00 AM in the dining room on the second floor, the residents that were in attendance were swatting at the gnats throughout the meeting. The residents stated that at one time, the problem with the gnats were brought under control, but currently, it has been an ongoing problem.</p> <p>A meeting was conducted with the Regional Director of Operations (RDO) Staff # 5 and the DON on 1/11/24 at approximately 10:38 AM after the resident council meeting, to make the facility aware of the resident's concerns. They told the survey team that the building is treated weekly for pest concerns.</p> <p>The Maintenance Director (MD) provided maintenance logs of the facility's pest control services. According to the log, the facility was last treated on 1/7/24 for fruit flies on second floor and on 9/1/2023 for fruit flies in kitchen area. During a follow-up meeting with the MD and the Administration team, they stated that the plan moving forward is to treat the building more frequently and as needed.</p> <p>All concerns were discussed with the Administration team at the time of exit on 1/26/24 at 5:05 PM.</p>		