STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215328	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Pineview	9106 Pineview Lane Clinton, MD 20735

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of administrative and all pertinent documents, and interviews with facility staff members, it was determined that the facility failed to provide Resident #1's representative with a copy of the resident's medical record timely. This was evident for 1 of 2 residents reviewed during a complaint survey.The findings include:On 12/30/25 the Office of Health Care Quality received a complaint concerning the facility not providing a copy of Resident #1's medical record after a written request. Review of complaint 2657295 on 01/12/26 at 10:30 am revealed an allegation that the facility failed to provide a copy of Resident #1's medical record when requested.Review of Resident #1's clinical record on 01/12/26 revealed that Resident #1 was admitted to the facility on [DATE] and has been deemed incapable of making all medical decisions by 2 physicians on 04/08/24.A review of the facility Access to PHI (protected health information) policy on 01/12/26 revealed that All requests should be submitted in writing and if unable to provide a request in writing, the staff member obtaining the oral request will document in writing the requested information. Under Timing: The facility must act on all requests for access or inspection as soon as is practicable, within 48 business hours for current patients.In an interview with the facility Director of Nurses (DON) on 01/12/26 at 11:30 am, the DON confirmed that Resident #1's representative was his/her mother and that Resident #1's representative can request and ask for copies of Resident #1's medical records but must go through the process.In a follow-up interview with the DON on 01/12/26 at 1:11 pm, the DON stated that the facility does not have a current medical record request for Resident #1 but that she would ask.In an interview with the Director of Medical Records on 01/12/26 at 1:33 pm, the Director of Medical Records confirmed that the facility received a medical record request for Resident #1's medical record on 12/29/25 but the family had not completed the paperwork and returned it to the facility.

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: 215328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Future Care Pineview		STREET ADDRESS, CITY, STATE, ZIP CODE 9106 Pineview Lane Clinton, MD 20735	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of medical records and all pertinent documents, and staff interview, it was determined that the facility failed to notify 1) Resident #1's representative in a timely manner after a significant change occurred, and 2) immediately notify a resident's physician and representative when a resident developed tachycardia. This was evident for 2 (Resident #1 and #2) of 2 residents reviewed during a complaint survey. The findings include: 1) On 12/30/25 the Office of Health Care Quality received 2 complaints, 2657295 and #2704179, concerning the facility staff notifying Resident #1's representative when there was an issue with seeing a medical consultant. Review of Resident #1's clinical record on 01/12/26 revealed that Resident #1 was admitted to the facility on [DATE] and has been deemed incapable of making all medical decisions by 2 physicians on 04/08/24.Further review of Resident #1's medical record revealed a podiatry consult dated 08/28/2025 that indicated Resident #1 refused to be seen by the facility podiatrist. The facility podiatrist indicated that the nursing unit manager was made aware and requested the nursing staff to call Resident #1's representative and inform them of the refusal.A review of nursing progress notes completed by the nursing unit manager, dated 10/31/2025 at 3:32 PM, revealed documentation Resident #1 refused care on 08/28/2025 by telling staff to Stop, leave me alone. The 10/31/25 unit manager progress note did not indicate Resident #1's representative was notified at the time of the refusal.In an interview with the facility Director of Nurses (DON) on 01/12/26 at 12:38 pm, the facility DON stated that Resident #1 has a history of aggressive behaviors and the facility podiatrist was not able to assess Resident #1 due to fighting with the podiatrist on several consultant dates.In an interview with the corporate DON on 01/14/26 at 2:45 pm, the corporate DON confirmed that Resident #1's representative was not notified by the nursing staff on 08/28/25 when Resident #1 refused to be seen by the facility podiatrist.2) On 11/10/25 the Office of Health Care Quality received a complaint, 2664568, alleging that Resident #2 was not receiving quality of care.Review of the facility Physician notification of a Change in Resident Condition policy on 01/13/26 revealed under #2, It is the responsibility of the nursing staff to report any changes in a resident's condition to the physician/NP/PA and the responsible family members and document such notification in the resident's clinical record. The policy indicates the staff should notify a resident's physician about abnormal vital signs when a resting pulse rate is greater than 100 beats per minute.Review of Resident #2's clinical record on 01/12/26 revealed that Resident #2 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic respiratory failure, gastrostomy tube, ventilator dependent, seizure disorder, multiple sclerosis. Resident #2 is totally dependent upon the facility staff for all aspects of his/her care.Review of Resident #2's medical record on 01/12/25 revealed a respiratory therapist's progress, staff member #8, note dated 12/25/25 at 8:57 am that documented Resident #2's heart rate was observed to be 120 beat per minute and noted to be irregular. The respiratory therapist noted that this rapid irregular heart rate was a new onset. The respiratory therapist noted that the attending RN on the day shift of 12/25/25 was notified of Resident #2's tachycardia.In an interview with LPN #1 on 01/13/26 at 2:18 pm, LPN #1 stated that s/he would notify a resident's physician if a resident's pulse was identified as being greater than 100 beats per minute. When asked if s/he recalled being informed by another staff member of Resident #2's heart rate of 120 beats per minute on 12/25/25 LPN #1 stated that s/he was unable to recall being told Resident #2's pulse rate was 120 beats per minute on 12/25/25 during the dayshift. A review of Resident #2's December 2025 medication administration record (MAR) on 01/13/26 reveled LPN#1 administrated a dose of the blood pressure medication, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol, 25 mg, enterally at 9 am on 12/25/25. LPN #1 documented Resident #2's blood pressure as being 140/78 with a pulse of 120 beats per minute. When asked, LPN #1 was unable to recall documenting a pulse of 120 beats per minute when administering a dose of Metoprolol to Resident #2. The facility DON and corporate nurse were aware of the conversation with LPN #1 as they were also in the room during the interview.