

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Future Care Capital Region		STREET ADDRESS, CITY, STATE, ZIP CODE  1051 Brightseat Road Landover, MD 20785	

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 - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49815</p> <p>Based on observations and interviews, it was determined that the facility staff failed to ensure that residents were provided reasonable accommodations as evidenced by call lights not readily available for Residents (#6, #46, #62, #97, 100, #124). This was found to be evident for 6 out of 6 residents reviewed for accommodation of needs.</p> <p>The findings include:</p> <p>During the initial tour of the PPCU-1 unit on 7/15/2024 at 9:15 AM, the surveyors observed the following residents without a call light in reach. Resident (#6) was in bed and the call light cord was observed hanging on the oxygen gauge on the wall, and Residents (#62 and #100) were in bed and the call light was observed on the floor. In addition, the surveyors observed that Residents (#46, #97 and #124) did not have an available call light.</p> <p>On 7/15/2024 at 11:00 AM the surveyors conducted an interview with the Regional Clinical Services Manager (RCSM) RN #2 on the PPCU-1 unit after the surveyor's initial tour. The surveyors conveyed to the Regional Clinical Services Manager (RCSM) RN #2 that call lights were not available or within reach for these residents. The Regional Clinical Services Manager (RCSM) RN #2 confirmed that the expectation is that call lights were to be available for residents. In addition, the Regional Clinical Services Manager (RCSM) RN #2 stated that she would have a unit audit conducted and an inservice regarding call bell light accessibility.</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
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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45733</p> <p>Based on medical record review and interviews it was determined that the facility failed to ensure: 1) the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) in place and 2) to identify a resident's surrogate as per the authority granted by the Health Care Decisions Act. This was found to be evident for 2 (Resident #116 and #448) out of 5 residents reviewed for the MOLST as part of the instruction.</p> <p>The findings include:</p> <p>MOLST is a medical order form that relays instructions between health professionals about patient care. The MOLST form certifies orders that were agreed to by a patient or a patient's health care agent as named in the patient's advance directive. MOLST determines resuscitation status and includes other 8 sections of treatment choices, for example, medication administration and nutrition.</p> <p>1) Interview, on 07/16/24 at 09:22 AM, found that Resident #116 was confused, only knew his name and unable to understand simple questions. The family at the bed side stated that he/she had experienced severe mental deterioration after his/her last hospitalization in intensive care unit on 06/11/24.</p> <p>Record review, on 07/16/24 at 09:40 AM, of Resident #116's admission record revealed that the resident was readmitted to the facility on [DATE] with the diagnosis of acute hypoxic respiratory failure and hemorrhagic gastric shock in intensive care.</p> <p>Further review found that a MOLST form, dated 06/11/24, erroneously served as the resident's current certification/orders for health care decisions (from the University Maryland Emergency Department) as if Resident #116 still had the full mental capacity. Clearly, the facility did not have one done when he/she had returned to the facility on [DATE] and obtain a proper advance directive to direct his care.</p> <p>However, on 07/05/24, the facility staff had completed Resident's #116's assessment of Brief Interview for Mental Status (BIMS). The resident's total score was 3 out of 15 which indicated that his/her cognitive state was severely impaired.</p> <p>The Brief Interview for Mental Status (BIMS) test has a score from 0 to 15 points. A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderate impairment, and 0 to 7 suggests severe impairment.</p> <p>During the interview, on 07/16/24 at 3:33 PM, the Unit Nurse Manager Staff #10 confirmed that Resident #116's MOLST was outdated and there should have been 2 medical staff to certify the incapacity to make an informed decision. During further interview, Nurse Practitioner Staff #25 agreed that the resident's mental state made him/her incapable of making any informed decisions and should have an advance directive on file.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, 07/16/24 at 3:43 PM, the Regional Clinical Services Manager was made aware of the above deficiency practice as a concern</p> <p>49815</p> <p>2) On 7/17/2024 at 8:20 AM the surveyor conducted a record review of Resident #448's medical record.</p> <p>During the medical record review, it was revealed that Resident #448 had a Maryland Medical Orders for Life-Sustaining Treatment (MOLST) dated 7/1/2024. The MOLST indicated that there was a discussion with and the informed consent of the patient's surrogate as per the authority granted by the Health Care Decisions Act. The surveyor was unable to locate a surrogate identification form after further review of Resident #448's medical record.</p> <p>On 7/25/2024 at 10:00 AM the surveyor requested a copy of Resident #448's MOLST. The Regional Clinical Services Manager (RCSM) RN (Registered Nurse),#1, provided a copy of Resident #448's MOLST and conveyed to the surveyor that there was no surrogate listed. The Regional Clinical Services Manager (RCSM) RN #1 further conveyed that the Social Services Department stated they were on it when she approached them regarding the surrogate form.</p>		

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<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>49815</p> <p>Based on interviews and medical record review it was determined that the facility failed to provide notification to the Ombudsman of the resident that transferred to the hospital. This was evident in 1 Resident (#24) out of 1 Resident reviewed for hospitalization s.</p> <p>The findings include:</p> <p>On 7/17/2024 at 7:30 AM the surveyor reviewed Resident #24's medical record. The review of the medical record revealed that Resident #24 was transferred to the hospital on 4/25/24 and 5/4/2024.</p> <p>In an interview at 8:15 AM on 7/19/2024 the surveyor requested from the Regional Clinical Services Manager (RCSM) Registered Nurse (RN) #1 the documentation of the Ombudsman notification of Resident #24's transfer to the hospital on 4/25/24 and 5/4/2024.</p> <p>In a follow-up interview with the Regional Clinical Services Manager (RCSM) RN #1 at 8:45 AM on 7/19/2024 the RCSM RN #1 stated to the surveyor that the notification to the Ombudsman had not been completed for Resident #24's transfers to the hospital on 4/25/2024 and 5/4/2024.</p> <p>At 9:20 AM on 7/19/2024 the Nursing Home Administrator (NHA) provided the surveyor with an email that she sent to the Ombudsman today and a computer-generated list Discharges 5/1/2024 to 5/31/2024 dated with today' s date 7/19/2024. The email that the Nursing Home Administrator sent to the Ombudsman included attachments of computer-generated lists of all discharges from November 2023 through June of 2024. The Nursing Home Administrator stated that notification to the Ombudsman had not been completed since November as the former Administrator performed this task and I have a plan going forward that the Social Services Department will be assigned this task.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>45733</p> <p>Based on medical record review and staff interview it was determined that the facility failed to notify the resident/resident representative in writing of the bed hold policy when the resident was transferred/discharged from the facility to an acute care facility. This was evident for 2 (#116 and #53) of 3 residents reviewed for hospitalization .</p> <p>The findings include:</p> <p>A Bed Hold is the act of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . It must be provided to all facility residents regardless of payment source. The Bed Hold policy should be disclosed in the admission packet during an initial admission to the facility and it should be disclosed to resident/resident representatives at the time of transfer.</p> <p>1a) During the interview, on 07/15/24 at 12:23 PM, it was revealed that the family was notified by phone on 06/11/24 regarding the transfer of Resident #116 to the hospital.</p> <p>Record review, on 07/17/24 at 12:19 PM, revealed that a transfer order and a transfer form were in place dated 06/11/24 at 10:05 AM. No bed hold policy was found in the chart nor in the electronic system. No documentation from the social workers as well.</p> <p>During further interview, on 07/18/24 at 10:49 AM, the Unit Nurse Manager Staff #10 stated that the bed hold policy was not given to Resident #116 nor to the family. The Regional Clinical Services Manager who was notified of the above deficiency practice as a concern.</p> <p>1b) A closed record review, on 07/22/24 at 11:58 AM, revealed that Resident # 53 was transferred out, on 07/04/24 at 13:51 PM, with the Nursing Practitioner Staff #25's order. However, the transfer notification to the family was not documented and there was no bed hold policy in place.</p> <p>During the interview, on 07/24/24 at 10:20 AM, the Regional Clinical Services Manager was able to clarify that the family was notified in a change in condition evaluation page by Nurse Staff #27 on 07/4/24 13:36 AM. Additionally, she provided hard copies of documents to support that the bed hold policy was issued.</p> <p>Record review, on 07/25/24 at 11:19 AM, revealed those hard copies only included an Emergency Department transfer form and a notice of facility-initiated transfer form. No bed hold policy was found. During further interview, the Regional Clinical Services Manager was informed that the documentation that she had provided did not include a bed hold policy, which was a concern</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50503</p> <p>Based on medical record reviews and interviews, it was determined that the facility staff failed to ensure: 1) that Resident (#131) was administered medication and 2) an outside medical appointment was scheduled for Resident (#435) in a timely manner. This was found to be evident for 2 (Resident #131 and #435) out 2 residents reviewed for Quality of Care.</p> <p>The findings include:</p> <p>1) During record review for Resident #131 on 07/23/24 at 01:29 PM, it was documented that Resident #131 had been evaluated by a medical provider on 05/26/24 for complaints of nausea without vomiting. The surveyor reviewed the medication administration record, it was revealed that Resident #131 did not receive the medication as ordered.</p> <p>During an interview with the Director of Nursing (DON) on 07/24/24 at 08:20 AM, she was asked to provide records that showed the resident received medication per their complaint. The DON reported she did not know if the medications were given, and that progress notes stated they were awaiting delivery of the medication.</p> <p>A Pyxis MedStation is an automated medication dispensing system. Automated dispensing machines provide secure medication storage on patient care units, along with electronic tracking of the use of narcotics and other controlled medications.</p> <p>During an interview with the DON on 07/24/24 at 11:09 AM, she confirmed she spoke with another facility staff member who could not remember whether the resident was administered medication or not. The DON also confirmed the medication was shown on the facilities' pyxis formulary list and was available for Resident #131.</p> <p>42783</p> <p>2) On 07/29/2024 at 9:27 AM a review of Resident #435's medical record review revealed documentation that the resident diagnosed with spinal stenosis complained of continued back pain. A review of the resident's Medication Administration Record revealed the resident was administered pain medications ordered for back pain.</p> <p>On 07/29/2024 at 9:35 AM a review of Physician orders for Resident #435 showed an order for an Ortho consult for spinal stenosis placed on 03/23/2022. Further review of the Physician orders revealed an appointment was made 14 days after the consultation was ordered on 04/06/2022 for an appointment on 05/25/22.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 07/29/2024 at 10:30 AM, the Director of Nursing (DON) stated that the process to send a resident to an outside appointment is as follows: the Physician would place the order for a consult, either the Unit Manager or Nurse would review the Physician's orders the next day and print out any orders that requested a consult. The Unit Secretary would speak with the resident and/or family member to see if they had a provider they preferred. The Unit Secretary would then call and schedule an appointment with the outside Provider and set up transportation unless the family wanted to do so.</p> <p>The DON further explained the facility's expectation is that an appointment would be scheduled within a short period of time of when the consult was first ordered. The DON stated she would investigate the Ortho consult ordered for Resident #435 on 03/23/22.</p> <p>On 07/29/2024 at 12:43 PM, the DON stated that she looked through emails and medical records and could not identify the reason for the delay in scheduling Resident #435's Ortho Consult appointment. The DON stated that the delay was not the facility's normal practice.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>49815</p> <p>Based on observations, interviews and record reviews it was determined that the facility failed to follow appropriate tube feeding care and services. This was evident in 4 (Resident #24, #62, #83 and #100) out of 4 residents reviewed for tube feeding management.</p> <p>The findings include:</p> <p>Enteral tube/feeding tube/gastrostomy tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation. The state of being fed by a feeding tube is called gavage, enteral feeding or tube feeding. A variety of feeding tubes are used in medical practice. The tube is inserted through the abdomen and into the stomach or intestines. Enteral feeding syringes are designed for delivering enteral tube feed, water, and medications via enteral feeding tube and/or to aspirate (suction) a feeding tube.</p> <p>On the initial tour of the PPCU-1 unit on 7/15/2024 at 9:15 AM the surveyors observed Resident #62, #83 and #100 in bed with a 60-cc enteral feeding syringe at the bedside which was not labeled with a date. In addition, the surveyors observed the tube feeding bag and tubing that hung on a pole in Resident #24's room was not labeled.</p> <p>The surveyors interviewed the Regional Clinical Services Manager (RCSM) RN #2 at 11:00 AM on 7/15/2024 after the surveyors' initial tour on the PPCU-1 unit. The surveyors conveyed to the Regional Clinical Services Manager (RCSM) RN #2 that tube feeding syringes and tube feeding bag were not labeled. The RCSM RN #2 conveyed to the surveyors that the expectation should be that the tube feeding supplies were to be labeled and that an audit and in-services would be conducted regarding labeling tube feeding supplies.</p> <p>The surveyor conducted a medical record review of Resident #62, #83 and #100's medical record on 7/18/2024 at 9:45 AM. The medical record review revealed that Residents #62, #83 and #100 had physician orders that read Enteral Feed Order every night shift Change syringe every day. In addition, Resident #24 had a physician's order that read Enteral Feed Order one time a day for nutrition and hydration Hang enteral feeding as ordered (up time) at 6 PM each day and Downtime at 6 AM or until volume of 600 ml enteral feeding administered.</p> <p>The surveyor conducted a review on 7/18/2024 at 10:10 AM of the Future Care Health and Management Corporation Nursing Practice Manual - Tube Feeding: Gastric Syringes, Enteral Spiking and Tube Feeding Protocol dated August 2023. The review revealed that the gastric syringes were to be changed every 24 hours and were to be labeled with the resident's name, date and room number and placed at the residents' bedside. In addition, the review revealed that the resident's name, room number, date, time and rate were to be written on the enteral product label, and that date and time were to be written on the tubing label.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49815</p> <p>Based on observation, medical record review and interviews it was determined that the facility failed to follow appropriate respiratory care and services. This was evident in 2 (Resident #24 and #62) out of 3 residents reviewed for respiratory care.</p> <p>The findings include:</p> <p>On the initial tour of the PPCU-1 unit on 7/15/2024 at 9:15 AM the surveyor observed an oxygen humidifier bottle dated 7/3 attached to the oxygen gauge on the wall in Resident #24's room.</p> <p>The surveyor observed Resident #24 in bed with oxygen in place to the nostrils at 12:29 PM on 7/16/2024.</p> <p>The Minimum Data Set (MDS) is a tool used by the Centers for Medicare and Medicaid Services (CMS) to standardize assessments and care management for residents of Medicare and Medicaid certified nursing homes. The MDS process evaluates a resident's functional capabilities and clinical needs, including their treatments, therapies, and psychosocial functioning. This information helps nursing home staff identify health problems and improve care management. MDS assessments are typically conducted every three months or more, depending on the situation.</p> <p>The surveyor at 8:30 AM on 7/19/2024 completed a record review of Resident #24's medical record. During the medical record review, it was revealed that the resident did not have a physician order for the oxygen. Further review of the medical record revealed that Resident #24's care plan had an intervention for, administer oxygen as per PRN (as needed) order and the annual Minimum Data Set (MDS) assessment had oxygen therapy checked as a special respiratory treatment.</p> <p>At 12:15 PM on 7/19/2024 the surveyor reviewed the Facility's oxygen policy and procedure that was received from the Regional Clinical Services Manager (RCSM) Registered Nurse (RN) #1. Upon review of the Future Care Health and Management Corporation Nursing Practice Manual - Respiratory Therapy: Oxygen Therapy, it indicated that a physician order must be written before therapy is initiated. The order must include flow rate and vehicle for delivery. In an emergency situation, until a physician can be reached, oxygen may be applied up to five liters per nursing judgement.</p> <p>On 7/25/2024 at 11:25 AM during an interview with the Regional Clinical Services Manager (RCSM) RN #1 the surveyor conveyed that Resident #24 had documentation in the medical record of an intervention on the care plan for oxygen PRN, and that oxygen was checked on the significant change MDS dated [DATE]. In addition, the surveyors observed the resident with oxygen in place to nostrils, but there was no current physician order for oxygen therapy for Resident #24. The Regional Clinical Services Manager (RCSM) RN #1 stated that she would investigate this.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 1:30 PM on 7/25/24 during a follow-up interview with the Regional Clinical Services Manager (RCSM) RN #1, the surveyor inquired about the oxygen for Resident #24. The Regional Clinical Services Manager (RCSM) RN #1 confirmed that the resident did not have an order for oxygen but does have an order now. The RCSM RN #1 further stated that the resident did have an order for oxygen previously, but when the resident discharged to hospital and returned the order for oxygen was not ordered by the physician. Resident #24 was recently hospitalized on [DATE] and 5/4/2024.</p> <p>A tracheostomy is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea from outside the neck. A person with a tracheostomy breathes through a tracheostomy tube inserted in the opening.</p> <p>On the initial tour of the PPCU-1 unit on 7/15/2024 at 9:15 AM the surveyors observed Resident #62 in bed with a tracheostomy, and there was not a manual resuscitator bag (ambu bag) included with the emergency supplies in Resident #62's room.</p> <p>On 7/15/2024 at 11:00 AM the surveyors conducted an interview with the Regional Clinical Services Manager (RCSM) RN #2 on the PPCU-1 unit after the surveyors' initial tour. The surveyors conveyed to the Regional Clinical Services Manager (RCSM) RN #2 that there was not an ambu bag included with the emergency supplies in Resident #62's room. The Regional Clinical Services Manager (RCSM) RN #2 stated that an audit and in-service would be conducted regarding emergency supplies.</p> <p>The surveyor conducted a record review of Resident #62's medical record on 7/19/2024 at 10:30 AM. The medical record review revealed that Resident #62 had physician orders for Respiratory Therapy to ensure emergency supplies are at bedside: backup trach, 5-10 ml syringe, manual resuscitator bag and Respiratory Therapy to change manual resuscitation bag every 6 months and place at residents bedside.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>50503</p> <p>Based on medical record review and interviews, it was determined that the facility staff failed to provide a follow up after a psychiatric consult for (Resident #60). This was evident for 1 out of 1 resident's reviewed for physician services.</p> <p>The findings include:</p> <p>During a review of Resident #60's physician orders conducted on 07/18/24 at 01:26 PM, the surveyor reviewed an order for a psychiatric consult ordered on 01/24/23. Following the order, a psychiatric consult community Health Services completed an evaluation for Resident #60 on 01/26/23. It was documented in the subject area under the PLAN that the patient did not require two antidepressants based on current presentation.</p> <p>During an interview with the Director of Nursing (DON) on 07/25/24 at 01:39 PM, she was asked about the documented psychiatric plan for the resident and was also asked about the follow-up physician or nursing notes based on the psychiatric consult conducted by the community Health Services.</p> <p>During an interview with the DON on 07/26/24 at 10:38 AM, she stated that the resident was found to have depressive symptoms before the consult with the community Health Services on 01/26/23. The DON reported the consult was placed based on Resident #60's presentation from a previous hospital visit. This confirmed the rationale for the resident continuing with antidepressant medications. The DON further stated from her perspective that if the resident continued to have symptoms she wouldn't have necessarily taken the resident off the antidepressant medications but otherwise stated there was no additional record of follow up of physician or nursing notes based on psychiatric consult recommendation completed by the community Health Service on 01/26/23.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Future Care Capital Region		STREET ADDRESS, CITY, STATE, ZIP CODE  1051 Brightseat Road Landover, MD 20785	

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47758</p> <p>Based on interview, record review and observation, it was determined that the facility failed to ensure medications were administered as prescribed by the medical provider. This was found to be evident for 1 (Resident #337) out of 1 resident's reviewed for medication timeliness.</p> <p>The findings include:</p> <p>A medical provider, also known as a health care provider, is a licensed individual or organization that provides health care services.</p> <p>During an interview on 07/15/24 at 12:35 PM, Resident #337's daughter stated that the night nurse had changed the time on a seizure medication without checking it with the doctor. No documentation was found on the record related to the medication time change. The surveyor requested additional information from the facility.</p> <p>07/25/24 at 10:25 AM Review of the Clinical Incident Report written on 7/9/24, stated that Registered Nurse (RN) #22 did not administer a medication as ordered and scheduled. Education was provided to RN #22 on medication administration in relation to notifying the Medical Doctor or Nurse Practitioner before making any timing changes.</p> <p>07/22/24 at 12:59 PM, during an interview with Regional Clinical Services Manager regarding the medication time being changed the surveyor was told that the nurse did not document why she changed the time. The Administrator was asked what she would expect the nurse to do when a medication time was changed from the ordered administration time. She stated, I would expect the nurse to contact the physician before making any changes to the ordered medication times and that education to have been provided to the nurse who made the change.</p>

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NAME OF PROVIDER OR SUPPLIER  Future Care Capital Region		STREET ADDRESS, CITY, STATE, ZIP CODE  1051 Brightseat Road Landover, MD 20785	
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<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>47758</p> <p>Based on observations and interviews, it was determined that the facility failed to ensure sanitary and safe food handling practices were followed to reduce the risk of foodborne illness. This was found for 2 out of 4 food refrigerator and storage areas observed during the annual survey.</p> <p>The findings include:</p> <p>During the initial tour of the kitchen with the Food Service Director on 07/15/24 at 08:02 AM, the surveyor identified concerns with outdated food. Lemon pie was dated use by 2/14 with no open date or year in the freezer, a container was labeled opened 1/16 with no discard date or year in the dry storage area, and containers of teriyaki sauce and soy sauce were not labeled or dated in the cooking area. The Food Service Director stated that all items should be dated with the received, opened and discard dates including the year and she would educate staff.</p> <p>On 07/17/24 at 11:40 AM, the surveyor requested that Registered Nurse (RN) #11 to unlock the refrigerator door on the Vital Strong 2 (VS2) unit. An unlabeled, undated container of fruit, an undated bag with a resident name and room number, and a grey cooler bag with no name or date were found. When RN #11 was asked what the facility policy was for unlabeled food, the VS2 Unit Manager stepped up and stated, We throw it away. I don't know how the food got in there because we keep the door locked and don't allow family members to put stuff in without a name and date. I checked it this morning and everything was fine. The VS 2 Unit Manager #10 further stated staff would be educated.</p> <p>During an interview on 07/29/2024 at 8:01 AM, the Administrator acknowledged the concern with labeling and dating and stated the facility purchased a date labeler for the kitchen and labels to be used for the units for food stored in the unit kitchens.</p>		

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NAME OF PROVIDER OR SUPPLIER  Future Care Capital Region		STREET ADDRESS, CITY, STATE, ZIP CODE  1051 Brightseat Road Landover, MD 20785	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50503</p> <p>Based on medical record review and interviews, it was determined that the facility staff failed to accurately document the Morse Fall Scale assessments for (Resident #60). This was evident for 1 out of 1 resident's reviewed for falls.</p> <p>The findings include:</p> <p>The Morse Fall Scale (MFS) is a tool that estimates a patient's risk of falling in various settings by assigning a score between 0 - 45 and higher points.</p> <p>During a review of Resident #60's medical record on 07/18/24 at 08:42 AM, it was revealed that Resident #60 fell on ,d+[DATE], 10/22, 8/23, 2/24, and 3/24. A review of the MFS assessment dated [DATE] did not accurately record the past history of falls as noted above. Therefore the resident fall risk was assessed inaccurately at a fall risk factor for moderate risk for falls. A review of the MFS assessment dated [DATE] did not accurately record the past history of falls as noted above. Therefore, the resident fall risk was assessed inaccurately at a fall risk factor for low risk for falls.</p> <p>During an interview with the Director of Nursing (DON) on 07/25/24 at 11:55 AM, she was asked about the Morse Fall Scale assessments pertaining to Resident #60. She stated that she reviewed the resident's record and was aware of the incorrect documentation of the MFS post fall assessments but did not know why the past history of falls were not indicated.</p>		

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<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>50503</p> <p>Based on observations and interviews, it was determined that the facility staff failed to follow infection control practices before donning personal protective equipment (PPE). This was evident during an annual survey.</p> <p>The findings include:</p> <p>Personal protective equipment (PPE) is clothing or equipment that protects the wearer from injury or the spread of infection or illness. In healthcare settings, PPE can include items such as: protective clothing, helmets, gloves, face shields, goggles, and respirators.</p> <p>During observation on 07/24/24 at 12:25 PM, the surveyor observed the PPE cart with a sign posted that stated, Reminder, sanitize your hands before taking a gown. The sign was visible to everyone. The surveyor observed Licensed Practical Nurse Staff #28, remove PPE from the cart without performing hand hygiene before removing the PPE. The surveyor also observed two more facility staff remove PPE without performing hand hygiene first.</p> <p>During an interview with Registered Nurse Staff #29 on 07/24/24 at 12:28 PM, she was directed to the PPE cart, then asked what the process was for removing PPE from the cart. Staff #29 confirmed that staff should perform hand hygiene first before removing PPE. During the interview with Staff #29, two additional staff removed PPE from the cart without performing hand hygiene first.</p>		