STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215118	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FUTURE CARE OLD COURT	**5412 OLD COURT ROAD RANDALLSTOWN, MD 21133**

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure the development of a baseline care plan that included instructions needed to provide effective and person centered care within 48 hours of admission. This was evident for 1 out of 5 residents (Resident #5) reviewed during the complaint survey. The findings include: Review of Resident #5's medical record on 3/4/20 revealed the Resident was admitted to the facility on [DATE] from the hospital for rehabilitation. On admission the Resident was ordered Physical Therapy (PT) to evaluate and treat as needed. Further review of the resident's medical record revealed [REDACTED].#1 on 1/27/20. Continued review of the PT's daily treatment note for Resident #5 on 1/27/20 revealed Physical Therapist #1 documented the Resident demonstrates increased [DIAGNOSES REDACTED] both lower extremities limiting functional balance and endurance. Patient requires max assist with postural balance, weight shift and maintain functional sitting balance. Review of the Resident #5's care plans on 3/4/20 revealed a care plan for 1.) Risk for/Actual activity intolerance with no goals or interventions and 2.) Safety risk with no interventions. Further review of Resident #5's care plans revealed 3 additional care plans for pain, imbalanced nutrition and risk for impaired skin integrity. Further review of the resident's medical record revealed [REDACTED]. The Physical Therapist #1 daily treatment note for Resident #5 on 1/27/20 was reviewed by the surveyor with the Director of Rehabilitation (DOR) on 3/4/20 at 11:50 AM. The DOR was asked based on the Physical Therapist #1 documentation what would Resident #5 need when out of bed. At that time the DOR stated the Resident would need to be placed in a reclined high back wheelchair. During interview with Physical Therapist #1 on 3/4/20 at 2:14 PM, she stated she evaluated Resident #5 on 1/27/20 in bed. She stated her evaluation included positioning and she deemed the Resident would be safe in a reclined high back wheelchair. Physical Therapist #1 was asked how would the staff know that was what the Resident needed and she stated the staff usually comes to the department and ask. During interview with the 1st floor Unit Manager on 3/4/20 at 2:20 PM, the Unit Manager was asked how the facility staff know what a resident needs after a therapy evaluation. She stated the therapy staff enter orders and notes in the electronic medical record. Further review of Resident #5's medical record revealed no orders, therapy notes or baseline care plan to indicate the Resident needed to be in a reclined high back wheelchair. Interview with the Director of Nursing and Regional Nurse on 3/5/20 at 1:00 PM confirmed the surveyor's findings.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to ensure that medication regimens were free from unnecessary medications for residents. This is evident for 2 out of 5 residents (Residents #2 and #3) reviewed during a complaint survey. The findings include: 1. Review of Resident #2's medical record on 3/3/20 and 3/4/20 revealed the Resident was readmitted to the facility on [DATE]. Further review of Resident #2's medical record revealed that on 9/29/19 the physician ordered [MEDICATION NAME] 100 mg three times a day for hypertension, hold for systolic blood pressure less than 130. [MEDICATION NAME] is a medication used to treat high blood pressure. Review of the Resident's Medication Administration Record [REDACTED]#2's medical record revealed on 9/29/19 the physician ordered: [MEDICATION NAME]3 units every 6 hours related to diabetes. Hold if blood sugar less than 120. Review of the Resident's MAR for November 2019, December 2019 and January 2020 revealed the Resident received [MEDICATION NAME]when the Resident's blood sugar did not meet the parameters for administration on: 11/14/19 at 6:00 PM with a blood sugar of 115 12/4/19 at 12:00 AM with a blood sugar of 101 2. Review of Resident #3's medical record on 3/3/20 and 3/4/20 revealed the Resident was admitted to the facility on [DATE] from the hospital. Further review of the Resident's physician's orders [REDACTED]. Review of the Resident's MAR indicated [REDACTED]. During interview with Resident #3's responsible party on 3/4/20 at 11:02 AM, he/she stated when visiting the Resident on the evening of 1/31/20, he/she observed 3 patches on the Resident with no date or time. The responsibility party stated he/she notified the staff at the time. During interview with the Nurse Supervisor on 3/4/20 at 12:00 PM, she stated she observed Resident #3 with 3 [MEDICATION NAME]es with no date or time on them. The Nurse Supervisor stated she removed 2 of the patches and advised the Director of Nursing of the incident. Interview with the Director of Nursing and Regional Nurse on 3/5/20 at 1:00 PM confirmed the facility staff failed to administer medications as ordered by the physician.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to maintain medical records in the most accurate form for a resident. This was evident for 1 of 5 residents (Resident #5) reviewed during a complaint survey. The findings include: A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. Review of Resident #5's medical record on 3/4/20 revealed the Resident was admitted from the hospital on [DATE] for rehabilitation and medical management. Review of the Resident's hospital discharge summary dated 1/25/20 revealed the Resident had [DIAGNOSES REDACTED]. The hospital discharge summary physical exam included the Resident's power to his/her left upper and lower extremities was a 3 out of 5 and 1 out of 5 for the Resident's right upper and lower extremities. Further review of Resident #5's medical record revealed the facility staff completed a Nursing Admission Database assessment on 1/25/20 at 8:55 PM. The facility staff documented No to history of [MEDICAL CONDITION]. The facility staff documented motor control was within normal limits. The facility staff documented upper and lower extremities strength was within normal limits. Further review of the Nursing Admission Database the facility staff failed to [MEDICAL CONDITION] list of [DIAGNOSES REDACTED]. An anticonvulsant is a medication used in the treatment of [REDACTED].

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.