

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/27/2025
NAME OF PROVIDER OR SUPPLIER  Future Care Northpoint		STREET ADDRESS, CITY, STATE, ZIP CODE  1046 Old North Point Road Baltimore, MD 21224	

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 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide and implement an infection prevention and control program.  (continued on next page)

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, administrative and medical record reviews, and interviews it was determined that the facility failed to ensure that clinical staff followed the infection control processes related to the hanging of the nephrostomy tube bag off the floor. This was evident to be true for 1 (Resident #1) of 3 residents observed with urinary drainage bags during a complaint survey. The findings include: A nephrostomy bag is a drainage bag that collects urine directly from the kidney through a tube to outside of the body. On 10/23/2025 at 08:00 AM the surveyor initiated a tour of the 2nd floor clinical unit. Breakfast trays were being served at that time. At 08:15 AM the surveyor observed resident #1 in room [ROOM NUMBER] in bed by the door. The surveyor observed two bags containing urine on the left side of the bed, bag A was a foley catheter bag cover in place, bag B was the nephrostomy bag lying on top of a white towel folded on the floor mat to the left of the bed. At 08:20 AM the surveyor observed LPN # 5 enter the resident's room, greeted the resident and asked the resident if he/she had any needs. On 10/23/2025 at 08:25 AM the surveyor interviewed the assigned LPN # 5, who stated that she has been an employee with the facility for the past eight months. The surveyor asked LPN #5 to explain the types of urinary drainage tubes the resident currently had in place. LPN #5 stated the resident had a left nephrectomy and a left urostomy bag. The surveyor pointed out that the left nephrectomy bag was resting on a towel on top of the fall mat on the left side of the resident's bed. The surveyor asked LPN #5 to explain why the left nephrostomy bag would be on the floor as opposed to hanging on the side of the resident's bed off the floor. LPN #5 stated that sometimes nephrostomy bags leak so placing the bag on top of a towel on the fall mat would prevent the urine from running onto the floor of the resident's room. LPN#5 stated that when she left her shift yesterday that nephrostomy bag was hanging on the left side of the bed and was off the floor; therefore the night shift must have placed the left nephrostomy bag on the towel on the floor mat next to the resident's bed. Additionally, LPN#5 did not make any attempt to hang the nephrostomy on the left side of the resident's bed rather than to have the nephrostomy bag remain on the towel on top of the floor mat, on the floor. On 10/24/2025 at 10:11 AM the surveyor observed the resident's left nephrostomy bag was hanging from the bedrail however the cap of the nephrostomy bag was touching the floor. On 10/24/2025 at 10:18 AM the surveyor conducted an interview with the two second floor unit managers, staff #6 and staff #7 regarding Resident #1. The surveyor shared the observation of the nephrostomy tube bag was not hanging from the frame of the bed/bed railing and was lying on a towel on the fall mat on 10/23/2025 and that the surveyor observed that the nephrostomy bag's cap was touching the floor on 10/24/25. Staff #7 stated that the bags should not be hitting the floor. Staff # 7 and Staff #6 stated that the clinical staff would be provided additional training by the infection control preventionist, staff # 8, related to adhering to the infection control policies in regard to keeping the nephrostomy drainage bag positioned off the floor and hanging appropriately the urinary drainage on the railing of the resident's bed appropriately. On 10/27/2025 at 10:34 AM the surveyor interviewed the infection control nurse, staff #8 regarding the facility's current infection control issues related to position of the nephrostomy bags hanging above the floor. Staff #8 stated once notified on 10/24/2025, that she recommended immediate education of the staff on the second floor related to the reports of non-compliance with the proper hanging of the Resident#1's left nephrostomy bag. On 10/27/2025 the surveyor discussed the concerns related to the deficient practice during the exit conference.</p>		