STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215176	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Canton Harbor	1300 South Ellwood Avenue 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews with facility staff, it was determined the facility failed to protect residents' personal health information from being publicly displayed. This was found to be evident for 3 (Resident # 4, # 30, and # 136) of 3 residents observed with Covid precaution signs posted during the facility's survey.Findings include: An observation was made of the 100-unit hallway on 9/15/25 at 9:00AM and the following concerns were identified:On the entrance doorway leading into Resident # 4 and Resident # 131's room, there was a sign posted indicating the following information: Stop Covid Precautions. Keep door closed. Additional instructions on personal protective equipment were also on the posted sign.On the entrance doorway leading into Resident # 30 room, there was a sign posted indicating the following information: Stop Covid Precautions. Keep door closed. Additional instructions on personal protective equipment were also on the posted sign.On the entrance doorway leading into Resident # 136 room, there was a sign posted indicating the following information: Stop Covid Precautions. Keep door closed. Additional instructions on personal protective equipment were also on the posted sign.An interview was conducted at the time of the observations with the Nurse #12 assigned to the unit and she stated that the residents in each of the rooms had Covid and that blue tape was also placed on the floor in front of each of the rooms.A subsequent interview was conducted with the Regional Clinical Nurse (RCN # 4) at approximately 1:30PM and she was made aware of the sign displaying the resident's personal health information and that it was not protected. The RCN confirmed that this was a violation of the residents' privacy and stated that the signs would be removed. A follow-up observation on the same date found the signs were replaced with droplet precaution signs.All concerns were discussed with the Administration team at the exit conference on 9/18/25.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, record reviews and interviews with the resident family and facility staff, it was determined the facility failed to provide documentation of a resident refusal to get out of bed. This was found to be evident during observations of 1 (Resident # 6) of 2 residents reviewed for activities during the survey.Findings include:Based on record review, Resident # 6 had the following but not limited diagnosis: Nontraumatic Intracerebral Hemorrhage (Stroke)On 9/15/25 at 8:45 AM an observation was made of Resident # 6 lying in bed in the bedroom. No activities were observed. Another observation was made on the same date at 12:30PM and the resident was lying in the bed in the bedroom. No activities were observed.During a family interview conducted on 9/15/25 at 2:17 PM the family expressed concerns about staff not getting the resident out of bed. The family went on to say that they visited Resident # 6 the prior weekend, and the resident was lying in bed. They stated that there was no wheelchair available, so they were unable to take the resident out of the room during their visit.Additional observations were made on 9/16/25 at 9:00AM and 4:30PM, and Resident # 6 was lying in bed. No activities were observed at the time of the observations. Staff #16, the resident assigned GNA was in the hallway near the resident room at 4:30PM and was asked what time she gets Resident #6 out of the bed and she stated that she does not usually get the resident up.On 9/17/25 at 8:30AM an observation was made of Resident # 6 and s/he was lying in bed in the bedroom. No activities were observed. The resident's assigned GNA #14 was in the hallway at the time of the observation and was asked if she gets the resident up out of bed to the chair, and she stated that the resident does not usually get up. She went on to explain that the resident was a fall risk and if the resident was up in the chair too long, the resident would try to get up.On 9/17/25 at 9:00AM Resident #6 self-care deficit care plan was reviewed. One of the goals listed was as follows: Resident will be able to tolerate Out of Bed (OOB) in chair- 2 hours. During an interview with the DON on the same date at 10:00AM, she was made aware of the surveyor observations of the resident being in bed for the past three days and the family's concern that staff did not get the resident out of bed. The DON stated that the resident refuses to get out of bed but was unable to provide documentation of non-compliance to the survey team. The DON acknowledged that the goal was for the resident to get up out of bed and will educate her staff to get the resident up and to document any refusals.All concerns were discussed with the Administration team at the exit conference on 9/18/25.