STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215219	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Irvington	22 South Athol Avenue Baltimore, MD 21229

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215219	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Irvington	22 South Athol Avenue Baltimore, MD 21229

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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on medical record review and staff interview, facility staff failed to follow a resident's plan of care to prevent injury to resident while providing care. This resulted in harm to Resident #6. This was evident for 1 of 3 residents reviewed for falls during a complaint survey.After the incident, the facility developed, initiated and completed a plan of correction to prevent further injuries to residents while providing care. Therefore, this deficiency will be cited as past non-compliance. The date of correction was 8/18/23. The findings include:Review of complaint intake MD00195745 (Iqies: 297381) on 7/17/25 at 10:52 AM revealed that Resident #6's family alleged that the resident fell from his/her bed and sustained a laceration to the head due to facility staff failing to provide adequate supervision to the resident. Review of Resident #6's medical record on 7/17/25 revealed a care plan which stated that the resident required 2 person assistance for toileting and bed mobility as of 2/21/21. Review of Resident #6's medical record on 7/17/25 revealed a progress note which stated that the resident had a fall incident on 8/12/23. The resident was observed with a laceration to the right side of his/her forehead as a result of the fall. The resident's forehead laceration was wrapped with gauze and the resident was transferred to the local hospital for evaluation and treatment. Continued progress note review on 7/17/25 at 12:00pm revealed that the resident returned from the local hospital after treatment on 8/13/23. The resident returned with forehead stitches that were used to close the forehead laceration. Interview with the Director of Nursing (DON) on 7/17/25 at 12:30pm confirmed that the Resident #6 had a fall incident on 8/12/23. The resident sustained a forehead laceration from the fall which required the resident to be transferred to the local hospital for treatment. The DON confirmed that a fall investigation was conducted, and the fall investigation revealed that the assigned nursing staff, Geriatric Nursing Assistant (GNA) #9, failed to follow the resident's care plan when he/she provided toileting care for the resident on 8/12/23. The facility developed a place of correction which included re-education of all nursing staff on reviewing the resident's plan of care prior to providing care to the resident and bed mobility techniques. Review of the facility's fall investigation on 7/18/25 at 9:47 AM revealed that the fall incident occurred on 8/12/23 at approximately 12:15 PM. The facility investigation contained a witness statement from GNA #9 dated 8/14/23 which stated that GNA #9 failed to follow the resident's care plan for 2 person assistance when providing toileting care. GNA #9's statement revealed that the resident fell from his/her bed and hit his/her head on the floor when GNA #9 provided toileting care to the resident alone. The statement was taken by former Administrator #18 and the DON was the witness. The DON provided the surveyor with the GNA Kardex for Resident #6 on 7/18/25 at 10:30 AM. Review of the GNA Kardex revealed that the resident required 2 person assistance for toileting care and bed mobility. Interview with former Administrator#18 on 7/22/25 at 9:30 AM confirmed that he/she conducted the interview with GNA #9 after the fall incident with the DON as a witness. Former Administrator #18 also confirmed that GNA #9 admitted to providing toileting care to resident #6 alone when the resident's care plan required 2 person assistance for toileting care and bed mobility. The facility's Plan of Correction included the following immediate action taken related to the facility's staff failure to follow Resident #6's plan of care which was verified by the survey team: The DON completed re-education of GNA#6 and all other nursing staff on reviewing bed mobility requirements prior to resident care and bed mobility techniques. Unit Managers/DON/ADON reviewed current residents' GNA Kardexes and care plans to ensure the appropriate bed mobility/fall prevention needs were documented. Reviewed the last 30 days of falls (ending in 8/14/23) involving current residents to ensure that no other residents were impacted by nursing staff failing to follow bed mobility plans of care. Conduct observations of residents requiring 1-2 person assistance with bed mobility daily for 2 weeks. Conduct random observances of 10% of residents requiring 1-2 person assistance for bed mobility for 2 weeks. Review incident reports daily in clinical meetings to ensure nursing staff were following the resident's plan of care. Charge nurses/supervisors continue random audits of 10% of residents requiring 1-2 person assistance with bed mobility weekly for 10 weeks after initial 2 week evaluation. Report results of the bed mobility observations and audits to the QAPI committee.