

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Future Care Homewood		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 North Charles Street Baltimore, MD 21218	
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. Based on record review and interview, it was determined that the facility failed to prevent an avoidable fall with injury when they failed to follow the resident's plan of care to provide two staff person assistance with bed mobility. This resulted in actual harm to Resident #103. This was evident for 1 complaint (#3096869) of 4 complaints reviewed during a complaint survey. Corrective measures were put in place prior to the start of the complaint survey, so this citation is past noncompliance with the compliance date of 6/30/26. The findings include: As defined by Harvard Health Medical School, a subdural hematoma occurs when a blood vessel near the surface of the brain bursts. Blood builds up between the brain and the brain's tough outer lining. A subdural hematoma is a life-threatening problem because it can compress the brain. An initial review of Resident #103's medical record done on 7/27/26 at approximately 11:00 AM revealed that the resident was admitted to the facility in February 2025. The resident required total assistance for all care needs and had diagnoses that included, but were not limited to, a history of stroke with residual right-sided weakness, acquired absence of right leg above the knee, and acquired absence of left leg above the knee. On 7/27/26 at 11:30 AM a review of complaint #3096869 revealed the allegation that Resident #103 was dropped out of their bed on 6/16/26 while they received care, had pain over their whole body, and was rushed to the hospital and found to have bleeding on the brain due to the fall. On 7/27/26 at 12:12 PM a review of Resident #103's medical record revealed progress notes, a change in condition form, and a transfer form, all dated 6/16/26, that described a fall incident that occurred while the resident received care in their bed by a nursing assistant (Staff #1). The resident was transferred to a local hospital for evaluation. A review of the resident's facility care plan, initiated on 2/27/25 revealed an intervention for two staff person assistance for bed mobility. A review of the nursing assistant Kardex (nursing assistant- specific plan of care) revealed an entry that for bed mobility (repositioning in the bed such as turning or pulling up), the resident needed 2 person assistance. On 7/27/26 at 12:30 PM further review of the facility medical record revealed a hospital summary dated 6/16/26 that stated that the resident was brought to the hospital due to a fall, and that they hit their head, and a CT scan showed a small acute right frontal subdural hematoma. A physician note written on 6/22/26, after the resident returned from the hospital stated the resident had a recent frontal subdural hematoma after a fall and that the resident required close neurological observation. On 7/27/26 at 1:26 PM an interview and observation of Resident #103 was conducted in the resident's room with the Director of Nursing (DON). The resident was awake and alert in bed, unable to speak clearly, but at their baseline per the DON. The interview with the DON then continued in a nearby private office and the DON was asked if he knew about the resident's fall incident. He said yes and described that the resident fell out of bed when being turned on their side with the help of only one nursing assistant (Staff #1). The DON confirmed that the nursing assistant should have had (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215249
		If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	another staff to assist her and that the facility had done an investigation, taken corrective action, and done education and follow up audits regarding care of dependent residents and he would provide evidence of this to the survey team. On 7/28/26 at 10:33 AM an interview was conducted with Staff #1 and the DON. Staff #1 said she was alone when she provided incontinence care to Resident #103 on 6/16/26. She described that she had rolled the resident towards herself and the resident's body continued to roll forward toward the edge of the bed and although Staff #1 tried to push the resident back on the bed, the resident's body continued to move off the edge of the bed and rolled onto the floor. Staff #1 said she knew that she should have had another staff to assist with the care of the resident. The facility's corrective action included: Education to Staff #1 and other nursing staff, regarding checking resident's care plan prior to providing care was completed on 6/16/26. Education to Staff #1 and other nursing staff, regarding use of proper technique and safety during bed mobility and positioning, completed on 6/17/26. Audits of random residents initiated on 6/16/26 that listed indicator/criteria of: fall during care, investigation initiated, staff followed the plan of care, resident sustained an injury, resident c/o [complained of] pain, pain management provided, neurochecks initiated, MD's order for diagnostic study, diagnostic study completed, resident was sent to the ER [emergency room]. Verbal counseling to Staff #1 completed on 6/16/26. Directed action plan for Staff #1, which included return demonstration/observation of staff performance, initiated on 6/16/26, which indicated a completion date of 6/30/26.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that the facility failed to report an incident of resident injury related to staff action that caused a resident serious bodily injury. This was evident for 1 complaint (#3096869) of 4 complaints reviewed during the complaint survey. The findings include: A subdural hematoma occurs when a blood vessel near the surface of the brain bursts. Blood builds up between the brain and the brain's tough outer lining. A subdural hematoma is a life-threatening problem because it can compress the brain. Resident #103 was admitted to the facility in February 2025. The resident required total assistance for all care needs and had diagnoses that included, but not limited to, history of stroke with residual right-sided weakness, acquired absence of right leg above the knee, and acquired absence of left leg above the knee. A review of complaint #3096869 revealed the allegation that Resident #103 was dropped out of their bed while they received care, had pain over their whole body, and was rushed to the hospital and found to have bleeding on the brain due to the fall. Review of Resident #103's medical record revealed progress notes, change in condition form, and a transfer form dated 6/16/26 that described a fall incident that occurred while the resident received care in their bed by a nursing assistant. The resident was transferred to a local hospital for evaluation. Further review of the medical record revealed a hospital summary dated 6/16/26 that stated that the resident was brought to the hospital due to a fall, and that they hit their head, and a CT scan showed a small acute right frontal subdural hematoma. Further review of the resident's medical record revealed an intervention on the resident's interdisciplinary care plan that stated the resident required two staff for bed mobility. A review of the nursing assistant Kardex (nursing assistant- specific plan of care) revealed the entry that the resident needed 2 person assistance when repositioned in bed. On 7/27/26 at 1:26 PM an interview was conducted with the Director of Nursing (DON) who confirmed that Resident #103 had a fall with injury when a nursing assistant attempted to reposition the resident without assistance. There was no evidence that the incident was reported to the state authority.		