

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER Frederick Crossing of Journey		STREET ADDRESS, CITY, STATE, ZIP CODE 30 North Place Frederick, MD 21701	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, it was determined that the facility failed to treat residents with dignity and respect by failing to respond to call lights in a timely manner. This was evident for 3 (#2, #4, and #5) of 3 residents reviewed for call light response times. The findings include: On 10/15/25 at 1:19 PM an interview with Resident #2 revealed s/he waited a long time for call lights to be answered and would yell for the staff to come to his/her room. The resident reported it had been an hour or longer which was why s/he would call the nurses' station and/or the front desk to get help. On 10/16/25 at 8:00 AM during an interview with Resident #4, s/he reported that 60% of the time staff do not answer the call lights. The resident reported that s/he has waited up to an hour at times. Resident #4 reported that the other day his/her colostomy bag busted at 6:45 AM and was not changed until 8:00 AM. An interview with Resident #5 on 10/16/25 at 8:05 AM revealed s/he had waited up to an hour at times for the call lights to be answered. The resident stated that s/he had not been turning on his/her call light during mealtimes and shift changes because staff were not available at those times. A review of the Resident Council meeting minutes on 10/16/25 at 12:13 PM revealed that the residents complained about the call lights not being answered in a timely manner in January, February, March, April, May, June, July, August, and October 2025. An interview with the Activities Director (AD) on 10/16/25 at 12:19 PM revealed that she verbally reported to the Director of Nursing (DON) the residents' concerns with call lights not answered in a timely manner. The DON was interviewed on 10/16/25 at 10:47 AM regarding the call light response times. She reported that she was aware of the concern voiced by the residents. She reported that since they do not have a call light system that tracks the time, she and other management staff will conduct audits of call light response times. She stated that they provide education to staff ongoing but continued to have an issue on shifts that did not have management assigned. The concerns were reviewed with the Nursing Home Administrator on 10/16/25 at 12:41 PM.		

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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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 ensure that an allegation of abuse was reported within the required timeframe. This was evident for 1 (#1) of 1 allegation of abuse. The findings include: A review of the facility's investigation file for the facility reported incident #2618838 on 10/16/25 6:29 AM revealed in the initial report that the facility became aware of Resident #1's allegation of abuse involving geriatric nursing assistant (GNA) #5 on 9/16/25 at 7:00 AM when the police came to the facility. However, the initial report noted that it was completed on 9/16/25 at 9:10 AM. There was no confirmation email included to verify the time the initial report was submitted to the State Agency (SA). On 10/16/2025 8:49 AM an interview with the Regional [NAME] President of Clinical Services revealed she had reviewed the previous Director of Nursing (DON) #6 email account and was unable to find the confirmation for the submission of the initial report. However, she found an email addressed to her and the Nursing Home Administrator (NHA) dated 9/16/25 and time stamped 9:57 AM from DON #7 stating that she had sent the initial report to the SA. Based on this evidence the report was submitted to the SA between 9:10 AM and 9:57 AM. An interview with Registered Nursing (RN) #7 on 10/16/25 at 5:21 AM revealed he became aware of Resident #1's allegation of abuse during the night shift (11:00 PM - 7:00 AM) on 9/16/25, however, failed to report it to administration until the end of the shift. During an interview with GNA #5 on 10/16/25 at 5:06 AM, she reported that she had become aware of Resident #1's allegation of abuse on 9/16/25 during the night shift by RN #7. She reported that she was interviewed by the police officer when he arrived. The concerns were reviewed with the NHA on 10/16/25 at 9:32 AM. Cross reference: F610		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that facility staff failed to protect their residents from an employee accused of abuse and to conduct a thorough investigation of an allegation of abuse. This was evident for 1 (#1) of 1 resident reviewed for abuse. The finding include: A review of the facility's investigation file for the facility reported incident #2618838 on 10/16/25 6:29 AM revealed in the initial report for 9/16/25 that Resident #1's alleged that geriatric nursing assistant (GNA) #5 slapped him/her on the face. The initial report noted that the facility became aware of the alleged abuse on 9/16/25 at 7:00 AM when the police came to the facility. However, a review of the witness statements revealed staff failed to document the date and time of when they were made aware of the allegation of abuse and when the police arrived at the facility. During an interview with GNA #5 on 10/16/25 at 5:06 AM, she reported that she had become aware of Resident #1's allegation of abuse on 9/16/25 during the night shift by RN #7. She reported that while she was on a break when Resident #1 came down the hallway with stool dripping from the resident's colostomy bag and the resident was asking for someone to change the bag. She stated she told the resident she would be back shortly to help him/her clean up. She stated she had a few minutes left on her break and when she clocked in around 4:00 AM she started cleaning up the stool in the hallway and then went into the room to help the resident get cleaned up. She stated that she finished and continued making rounds on the residents on her assignment. She stated that when she had finished 3 residents, she was approached by RN #7 about the allegation of abuse. She reported that the police showed up and she was interviewed by them and then told to go back to her assignment. On 10/16/25 at 8:17 AM a review of GNA #5 timesheet for 9/16/25 confirmed that she was on break from 3:30 AM until 4:00 AM and did not clock out until 12:22 PM. An interview with Registered Nursing (RN) #7 on 10/16/25 at 5:21 AM confirmed that he became aware of the abuse allegation during the 11:00 PM - 7:00 AM shift on 9/16/25, however, failed to report it to administration until the end of the shift. He reported that he was allowed to make the decision to remove the GNA from caring for residents after an allegation of abuse but chose not to because he did not believe that GNA #5 had abused Resident #1. He reported he moved GNA #5 to another hallway to work until the end of her shift. An interview with the previous Director of Nursing (DON) #6 on 10/16/25 at 8:57 AM via a phone call revealed she found out about the allegation of abuse for Resident #1 on 9/16/25 around the change of shift. She stated that at the time she was not aware of the name of the GNA accused, but RN #7 told her that he had moved GNA #5 because she was assigned to Resident #1 that night. DON #6 was made aware of the finding during the interview with GNA #5 and RN #7 and asked what her expectations were. She stated that when staff become aware of an allegation of abuse, she expected them to call her or the Nursing Home Administrator immediately. She stated that if RN #7 knew that GNA #5 was the accused GNA then she should have been suspended immediately. An interview with the NHA on 10/16/25 at 9:32 AM revealed he does not conduct the investigations; however, he was responsible for reviewing the investigation when it was completed. He reported that the DON would keep him up to date on the investigation course and findings. He stated he expected witness statements to include the dates and times to establish a timeline and ensure compliance with the regulations. He reported he failed to recognize this information was missing when he reviewed the investigation. Cross reference: F609		