

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  01/30/2026
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interview with staff it was determined the facility staff failed to ensure resident medical records were complete and accurately documented. This was evident for 1 (Resident #1) of 2 residents reviewed during the complaint survey. The findings include: The facility's report and investigation for Facility Reported Incident #2665129 was reviewed on 1/29/26 at 2:32 PM. The documentation revealed Resident #1 alleged that a staff member answered his/her call bell and hit him/her on the head on 11/7/25 at 10:21 PM. The facility reported the allegation to the State Agency and the local police, conducted an investigation, and submitted a Follow-Up Investigation Report to the State Agency. They were unable to verify the resident was struck on the head by staff as alleged. During the investigation witness statements obtained from staff revealed that Resident #1 was found sitting on the floor of his/her room on 11/7/25 at approximately 11:40 PM. Resident #1's medical record was reviewed on 1/29/26 at 4:16 PM. No documentation was found in the medical record regarding Resident #1's allegation of physical abuse or that s/he had an unwitnessed fall. On 1/30/26 at 9:44 AM the Administrator was made aware and asked to provide all fall and abuse allegation documentation from Resident #1's medical record related to the fall and allegation of abuse on 11/7/25. At approximately 11:24 AM on 1/30/26 Staff #1 the Infection Control Nurse provided an incident report dated 11/7/25 11:45, which reflected that Resident #1 was observed sitting on the floor next to his/her bed. The bottom of the page included PRIVILEGED AND CONFIDENTIAL - NOT PART OF THE MEDICAL RECORD - DO NOT COPY TEST. Staff #1 confirmed this report was not part of Resident #1's medical record. She also provided a skin assessment created 11/8/25 at 18:15 which indicated No Current Tissue Injury Noted and No skin issues noted. It did not reflect why the skin assessment was done. There was no documentation in Resident #1's medical record reflecting that s/he made an allegation of abuse, was found sitting on the floor. There were no assessments of the resident nor indication of interventions that were implemented by staff in response to each of the events. The Administrator was made aware of these findings on 1/30/26 at 2:40 PM.</p>

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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