STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederick Crossing of Journey	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, it was determined that facility staff provided substandard quality of care for a resident following an unwitnessed fall. This was evident for 1 of 2 observations of residents. The findings include:Assessment after a fall should include: before a resident can be moved, the nurse must assess them for an injury to the spinal column, obvious fractures, significant bleeding, and their level of consciousness. Overall, this assessment includes taking the resident's vital signs, assessing location and intensity of pain, respiratory status, circulation, and for signs and symptoms that a post-fall injury has occurred. If there are signs of an injury to the spinal column, a fracture, significant bleeding, or the resident's level of consciousness has changed, do not move the resident. Call EMS and provide supportive care until EMS arrives. (AAPACN [American Association of Post-Acute Care Nursing] Post-Fall Assessments 2021)Neurological Assessments (neurochecks): include a full set of vital signs B/P, pulse, respirations, and temperature), check pupils for size and reaction to light, weakness on one or both sides, level of consciousness. The purpose of the neurochecks is to monitor the resident for symptoms to indicate a brain injury falling a fall in which the resident is known to have hit their head or if it is unknown.On 5/1/26 at 11:07 AM an observation of Resident #2 revealed the resident's room door was cracked open and when the surveyor knocked the resident could be heard talking. When the surveyor entered the room, the resident was lying on the floor on his/her left side with their feet facing the bathroom. The resident was talking, but s/he was not making sense and some words were unintelligible. The bed was in a low position with fall mats on each side. The call light was on the floor next to the bed. The resident's over-the-bed table was pushed against the wall about 3 feet from the bed and had a full glass of juice, water cup, and a bag of goldfish on it. Geriatric Nursing Assistant (GNA) #3 was in the hallway and was made aware that the resident was on the floor. GNA #3 and GNA #4 came to the room. The Licensed Practical Nurse (LPN) #2 was in the hallway and heard GNA #4 state the resident had fallen again. LPN #2 entered the room and with the assistance of GNA #3 sat the resident up and was assessing his/her head for injuries. She then with the help of GNA #3 lifted the resident into a chair in the room. She looked at the resident's eyes and then checked the resident extremities for injuries. However she failed to conduct a neurological assessment referred to as a neurocheck. Although there had been 2 staff she asked them to get the vital signs equipment 10 minutes after the fall. GNA #3, who went to get the equipment returned stating that it was in the med cart. The nurse went to retrieve the equipment. She obtained the vital signs at 11:17 AM, but she failed to count the resident's respirations. The resident was placed in a wheelchair and taken to the nurses' station.At 5/1/26 at 11:30 AM she obtained a second set of vital signs minus the respirations. She failed to conduct a neurocheck on the resident. She was documenting a neurocheck sheet.A medical record review for Resident #2 on 5/1/26 at 11:55 AM revealed in the progress notes a visit note by Nurse Practitioner (NP) #8, that documented the resident had a condition called pancytopenia (the person has low blood counts of red blood cells, white blood cells, and platelets). Platelets assist with the blood's ability to clot. This condition placed the resident at a greater risk of bleeding in the brain after a head injury and required close monitoring after an unwitnessed fall.An interview with LPN #2 revealed she was aware she had not taken the resident's respiration with either of the vital (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs check. She stated that in the room the resident was shaking too much to get the respirations. When asked how she would count the respirations without a watch or a clock in the room, she stated she would use her phone and showed it to the surveyor. However, it was a digital clock with no seconds displayed (healthcare staff are taught to count the number of respirations for 15 - 60 seconds). She offered no rationale for failing to obtain respirations during the second neurocheck. When asked how she would conduct a neurocheck, she was able to verbalize the correct way, however she failed to do so. She stated she planned to do them later. An interview with the LPN Unit Manager (UM) #1 on 5/1/26 at 11:44 AM revealed that staff were expected to assess the resident for injuries before getting them up off the floor after a fall. This assessment should include: a head-to-toe assessment checking for injuries, obtaining a set of vital signs, and a neurological assessment. She stated respirations were a part of the vitals signs and a resident shaking should not interfere. She stated that the neurological assessment should include checking the resident's pupil reaction and having them grip your hands with their hands and push on your hands with their feet.The concerns were reviewed with the DON and she acknowledged the concerns. She stated that she provided one-on-one training with LPN #2 and that a head-to-toe assessment had been completed on Resident #2 to include respirations and a full neurocheck.Cross Reference: F689

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, record review, and interview, it was determined that facility staff failed to ensure that residents were free of accidents and hazards. This was evident for 1 (#2) of 2 residents reviewed for falls.The findings include:Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. A review of the facility's Fall Prevention Program dated 2/1/24 revealed in section 6. High Risk Protocols, c. provide interventions that addressed unique risk factors measured by the risk assessment tool; d. provide additional interventions as directed by the resident's assessment, including but not limited to an increased frequency of rounds and sitter, if indicated.A medical record review for Resident #2 on 5/1/26 at 11:55 AM revealed on 4/7/26 the resident had a care plan initiated for an actual fall on admission and remains at risk for falls related to a new environment, history of falls, weakness, diminished safety awareness, and balance problems. The goal was that the resident will maintain highest level of independence with mobility and safety, reducing the frequency of falls and injuries through staff intervention. The interventions were to place the resident on the secured unit, refer for physical and occupation therapy as needed, appropriate footwear, and keep frequently used items close to the resident. On 4/9/26 the facility added the interventions to encourage the resident to stay in high visible areas and keep floors and pathways clear of clutter. On 4/11/26 they added intentional rounds to meet the resident's needs, however, they failed to include a frequency of these rounds. On 4/24/26 they added a fall mat on the left side of the bed. Then on 4/13/26 an additional care plan for being at risk for falls and had experienced multiple falls since admission related to falls prior to admission, encephalopathy, lung cancer with metastasis to brain, failure to thrive, incontinence, and bipolar disorder was initiated. The goal was that the resident would not experience any serious injuries from the falls. The interventions initiated on 4/13/26 were to encourage the resident to wear nonskid footwear when out of bed, to ensure that the resident's call light was within reach while in bed, keep, and to review the root cause and analysis of the fall to determine the cause and intervene, and educate the resident, family, and caregivers of the cause. After a fall on 4/14/26, there was one intervention added: to encourage the resident to participate in activities. A review of the progress notes revealed a note from a visit conducted by Nurse Practitioner (NP) #8, dated 4/24/26, confirmed the resident had the diagnoses listed on the care plan for falls. In addition, the resident had pancytopenia (a condition where the person has low levels of red blood cells, white blood cells, and platelets) which increased his/her risk of bleeding. She noted the resident was pleasantly confused. A review of the evaluation tab revealed that the resident had falls on 4/7/26, 4/9/26, 4/12/26, 4/14/26, and 4/24/26. A review of the progress notes revealed the resident had a progress note dated 4/11/26, documented the resident had 2 falls that day. Another progress note dated 4/12/26, documented the resident had 2 falls that day. Although the resident experienced 8 falls, staff failed to escalate the level of supervision to ensure the resident's safety.During an observation of Resident #2 on 5/1/26 at 11:07 AM, upon which the surveyor found the resident's room door cracked open and the resident was observed lying on the floor in his/her room, Licensed Practical Nurse (LPN) #2 stated that this resident had multiple falls which was why they had the resident in bed. She stated that the resident had cancer that metastasized the brain and it was affecting his/her vision, and s/he had been falling frequently. An interview with geriatric nursing assistant (GNA) #3 on 5/1/26 at 11:07 AM revealed she checked on the resident throughout her shift; however, she had not set times or frequency that she checked on the resident. The care plan had failed to include the frequency of the checking on the resident. In addition, with the residentThe concerns were reviewed with the Director of Nursing on 5/1/26 at 1:37 PM and she stated that staff should not keep a resident in bed to prevent them from falling. She acknowledged that there was no escalation of supervision to ensure the safety of this resident.