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	06/17/2026

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 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 administrative record review and staff interviews, it was determined that the facility staff failed to immediately report an injury of unknown origin to the facility administration and failed to report the injury of unknown origin to the state agency immediately but not later than 2 hours after becoming aware of the injury. This was evident for 1 (#1) of 1 residents reviewed for a facility reported incident. The findings include: Per the Centers for Medicare & Medicaid Services for an injury of unknown origin, the nursing standard of practice dictates a systematic, four-step approach: immediate assessment of the patient, strict objective documentation, thorough internal investigation, and mandatory reporting to supervisors and regulatory authorities to rule out abuse or neglect. On 6/16/26 at 10:07 AM, a review of facility reported incident 3002787 alleged a staff member struck Resident #1 in the head during the night shift. Resident #1 reported the allegation to his/her representative, and the resident's representative then alerted the charge nurse. The resident alleged incident occurred on night shift, between 5/2/26 and 5/3/26 and Resident #1 was found to have redness to the left side of his/her forehead and an abrasion. Further review of the self-report revealed staff became aware of the incident on 5/3/26 at 12:20 PM, the Nursing Home Administrator (NHA) was notified of the incident on 5/3/26 at 12:30 PM, and the facility reported the incident to the state agency, the Office of Health Care Quality (OHCQ), on 5/3/26 at 1:10 PM. On 6/16/26 at 1:27 PM, the facility's follow-up investigation report form, which documented the steps taken by the facility to investigate the allegation, was reviewed. A summary of interviews with the alleged victim and/or responsible party documented a Geriatric Nursing Assistant (GNA) originally noted the discoloration to Resident #1's head when the GNA was passing trays, and the resident told the GNA that s/he had done it to him/herself. Resident #1's representative arrived at the facility around 12:30 PM and was told by the resident that someone had hit him/her in the head. The representative immediately notified the nurse. A summary of interviews with staff documented that the discoloration of Resident #1's left forehead was observed in the morning of 5/3/26 and Resident #1 told the GNA that s/he had done it to him/herself. Prior to the arrival of Resident #1's representative to the facility, The abuse allegation was not made by Resident #1 prior to the arrival of his/her representative's to the facility. The facility's investigation concluded that the allegation of abuse could not be verified or refuted due to insufficient information to determine whether or not the allegation had occurred. On 5/3/26, in a statement following the incident, GNA #3 stated s/he went into Resident #1's room on 5/3/26 at 9:15 AM to give the resident his/her breakfast tray and noticed a mark on the left side of Resident #1's face. GNA #3 asked Resident #1 if s/he had scratched it and the resident said no, that s/he had hit it. GNA #3 asked Resident #1 if the nurse knew about the bruise, and the resident said the nurse was aware. On 5/4/26, in a statement following the incident, Licensed Practical Nurse (LPN) #5 documented s/he was the nurse assigned to Resident #1 on the day of the incident (5/3/26) and around 8:30 AM, s/he went into the resident's room to administer medications. At that time, LPN #5 noticed a bruise on Resident #1's face and thought the bruise appeared old, and thought the resident may have scratched him/herself. LPN #5 did not ask the resident what happened because Resident #1 kept telling LPN #5 to get out and leave him/her alone. LPN #5 then left the room to continue with (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication pass. Resident #1's representative later passed LPN #5 in the hallway, entered the resident's room, then came out of the room and asked LPN #5 if s/he saw the bruise on Resident #1's face. LPN #5 told the representative s/he had seen the bruise and thought it looked old. The representative said it was not old and alleged someone from night shift punched Resident #1. LPN #5 then notified the supervisor. LPN #5, with the supervisor, went to Resident #1's room and were told by resident's representative that GNA #3 knew what happened to Resident #1's face. GNA #3, was contacted, came to the room and stated that when s/he asked Resident #1 what happened to his/her face, the resident said s/he hit it and the resident said that the nurse knew about it. GNA #3 stated s/he did not go to the nurse at that time because Resident #1 said the nurse was aware. The facility's investigation documented the bruise on Resident #1's forehead was observed by LPN #5 on 5/3/26 around 8:30 AM and GNA #3 observed the bruise on Resident #1's forehead in the morning of 5/3/26. The Administrator was not notified of the resident's left forehead bruise and abrasion, which was an injury of unknown origin, until 5/3/26 at 12:30 PM, when the facility staff were made aware of Resident #1's allegation of abuse which alleged the resident's forehead injuries were from from the abuse. The facility reported the abuse allegation to the state office on 5/3/26 at 1:10 PM, which was greater than 2 hours after the facility staff observed the injury of unknown origin on Resident #1's forehead. On 6/17/26 at 12:11 PM, during an interview, LPN #5 stated when s/he first saw the bruise on the resident's face, Resident #1 was asleep and s/he didn't want to wake him/her. LPN #5 state the bruise looked dark, and s/he assumed it was an old bruise. LPN #5 stated that because s/he works PRN (as needed), s/he wanted to look at his/her notes and investigate it as s/he had not seen the resident for days or weeks, and because of the color of it, assumed it was an old bruise. LPN #5 stated that s/he was going back to the resident's room for the 2nd time when s/he saw the resident's representative coming down the hall, found out about the resident's allegation and reported it to the supervisor. The concerns with the facility staff failing to immediately report an injury of unknown injury to the facility's administration was discussed with the Assistant Director of Nurses (ADON) and the Corporate Nurse on 6/17/26 at 2:49 PM. At that time, the Corporate Nurse acknowledged the concerns and stated that following the facility's investigation of the allegation of abuse, the facility had an Ad Hoc (impromptu) QAPI (Quality Assurance and Performance Improvement) meeting, however, late reporting had not been identified.

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(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 record review and staff interviews it was determined the facility staff failed to promptly conduct a thorough assessment of a resident after an injury of unknown origin. This was evident for 1 (#1) of 1 resident reviewed for abuse.The findings include:Per the Centers for Medicare & Medicaid Services for an injury of unknown origin, the nursing standard of practice dictates a systematic, four-step approach: immediate assessment of the patient, strict objective documentation, thorough internal investigation, and mandatory reporting to supervisors and regulatory authorities to rule out abuse or neglect. Complaint #3002103 and facility reported incident (FRI) #3002787 were reviewed concurrently on 6/16/26 at 9:35 AM. The complaint indicated that Resident #1 was punched 2 times by a geriatric nursing assistant (GNA), resulting in a gash on the left temple with bruising. The FRI's investigation documentation included statements signed by staff which revealed:LPN #5 stated she went to Resident #1's room around 8:30 AM to administer medication. Resident #1 asked her to just give me my (medication) and get out. At that time, I noticed a bruise to (Resident #1's) face. The bruise appeared old, and I thought maybe s/he scratched him/herself because s/he's known for scratching at hitting staff. I didn't ask him/her what happened because s/he kept repeating, (LPN#5) get out, leave me alone. I left his/her room and continued my med pass. She indicated that a few minutes later the resident's family member came in to visit and reported the resident had been struck by a GNA. The statement from RN #6 a Unit Manager/Shift supervisor indicated that she was alerted by LPN #5 before lunch, around 12 that the family of Resident #1 was reporting that someone hit (the resident); At which time she and LPN #5 went to the room to assess the resident. This was 3 1/2 hours after LPN #5 initially observed the injury. Review of the Visitor's Log confirmed Resident#1's family members signed in at 12:08 PM on 5/3/26. During an interview on 6/17/26 at 12:08 PM, LPN #5 was asked what she did when she first observed the injury to Resident #1's head/face on 5/3/26 at 8:30 AM. She indicated that the resident was asleep and she didn't want to wake him/her. So, she continued to pass medications then came back later.This varied from her signed statement in which she indicated that the resident was yelling at her to get out and leave me alone. LPN #5 went on to say the injury looked dark. She thought it looked old and she wanted to look at notes. She indicated that she continued to pass medications and by the time she came back to the resident the family member was there. She confirmed she was not informed about an injury or bruise during morning report from the previous shift. She was asked where she documented the initial assessment of the resident and injury. She indicated she put a note in the record, and the supervisor said she was going to handle it. She was asked if anyone initiated neurochecks She indicated yes, the supervisor said she'd handle it, I didn't do any neurochecks. Neurological Assessments (neurochecks): include a full set of vital signs(blood pressure, pulse, respirations, and temperature), check pupils for size and reaction to light, weakness on one or both sides, level of consciousness. The purpose of neurochecks is to monitor the resident for symptoms that may indicate a brain injury following a head injury or fall in which the resident is known to have hit their head or if it is unknown.Neurochecks should be started as soon as a potential head injury is identified and follow a protocol with a typical frequency of every 15 minutes x4, every 30 minutes x 2, every hour x 3, every 4 hours x 4 then every 8 hours x 3. This is to facilitate early detection if changes in neurological status occur, indicating a potentially serious head injury. A review of Resident #1's medical record on 6/17/26 at 9:00 AM revealed:An eINTERACT Change in Condition Evaluation completed by LPN #5 dated 5/3/26 12:44 PM. It summarized that the resident's family member reported the resident had a wound/bruise to left face and the resident reported that a GNA hit him/her on night shift. VS were obtained 5/3/26 12:46 PM. This was approximately 4 1/4 hours after LPN#5 initially observed the injury. The sections for Behavioral, Respiratory, Cardiovascular, Abdominal/GI, Genitourinary, Pain and Neurological, all indicated Not clinically applicable to the change in condition being reported.Skin Status Evaluation indicated that a skin assessment relevant to the change in condition was reported: described as Skin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tear and Wound; Not associated with significant pain or bleeding and described as apparently minor recent wound now developing redness, swelling or pain.Location and details: Site: Face, Description: left face. It did not identify the size, type, or color of the wound, if there was any bleeding or drainage, redness or swelling or the condition of the surrounding tissue. There was no assessment of the residents' pain level or changes in the residents' emotional wellbeing. There was no indication that neurochecks were started.On 6/17/26 at approximately 2:25 PM the acting Director of Nursing (DON) provided a Neurocheck Assessment log which indicated neurochecks were initiated at 1:45 PM by someone with the same initials as LPN#5. This was approximately 5 1/4 hours after LPN#5 initially observed Resident #1's injury. A Skin Evaluation note by the supervisor RN #6 on 5/3/26 at 2:46 PM, included only Left forehead bruise. There was no assessment of the wound. A Progress note by RN #6 at 8:55 PM described a discussion with the resident regarding the incident and included On his/her left temple there was 2 bruises areas, 1 was opened with no drainage noted. MD was notified She did not conduct a complete wound assessment. This was approximately 10 1/2 hours after LPN #5 first observed Resident #1's injury. The ADON and Corporate Nurse were made aware of these concerns on 6/17/26 at approximately 2:45 PM.