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	10/30/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48259 Based on record review and interviews, it was determined that the facility failed to obtain a resident's representative's signature or document refusal to sign the Notice of Medicare Non-Coverage (NOMNC) for a resident who was discharged from Medicare Part A services but had benefit days remaining and intended to remain at the nursing facility receiving non-skilled care. This was evident for 1 (#88) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification. The findings include: Residents with Medicare Part A have certain rights and protections related to financial liability and appeals. The financial liability, appeal rights, and protections are communicated to beneficiaries through notices given by providers to residents who are being discharged from Medicare services but have Medicare benefit days remaining. The notices include Notice of Medicare Non-Coverage (NOMNC). This must be issued at least two calendar days before the last day of Medicare coverage. The NOMNC informs the beneficiary of his/her right to an expedited review of services termination. The resident and/or their representative must receive a copy of the notice enough to appeal the decision to terminate the paid coverage. The facility must indicate that the notice was sent/and given within the specified time. A review was done on 10/28/24 at approximately 8:30 AM of Resident #88's Beneficiary Notification checklist completed by the facility. The review showed that Resident #88's Medicare Part A services started on 4/10/24 and ended on 5/15/24. Continued review noted that the facility initiated the resident's discharge from Medicare Part A services when benefit days were not exhausted. The further review noted a NOMNC for Resident #88 dated 5/10/24, not signed but contained a statement in place of the signature of the resident or representative that reviewed with Patient's brother via telephone. The review failed to show who did the notification and whether Resident #88's representative refused to sign the form. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	10/30/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #88's medical record contained a progress note by staff #2, social services director. The progress note stated, This social worker completed Notice of Medicare Non-Coverage (NOMNC) with patient's brother on this date per MDS [minimum data set assessment] rounding on this date. Patient's brother agreeable and understanding, signed documents on this date. This social worker made copy of documents, uploaded to electronic chart, copy provided to Business Office, original provided back to patient on this date. However, an earlier review of Resident #88's NOMNC did not contain a signature. In an interview with staff #2 on 10/28/24 at 10:58 AM, he said he usually mailed the NOMNC to residents' representatives who could not physically come to the facility to sign. However, the interview failed to show that a copy of Resident #88's NOMNC was mailed to his/her representative. Staff #2 continued to say that his documentation that the resident's representative signed the NOMNC, and a copy provided to the resident was inaccurate.

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	10/30/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on observation and interview it was determined that the facility failed to ensure staff reported areas in resident's rooms in need of repair to maintenance. This was found to be evident on one of the three units. The findings include: 1) On 10/22/24 at 12:50 PM the surveyor observed the bathroom of room [ROOM NUMBER] and found a white pillow on the floor and a fall mat leaning against the wall. The mat was frayed. On 10/28/24 at 2:02 PM the surveyor conducted an observation of room [ROOM NUMBER]'s bathroom with the unit nurse manager (Staff #9) and saw the pillow on the floor and the fall mat leaning against the wall. The surveyor noted the fall mat in the bathroom had multiple cracks. The unit nurse manager reported she would have the fall mat thrown out. 2) On 10/23/24 at 11:19 AM the surveyor observed the wall behind the B bed in room [ROOM NUMBER] with a large area of scrapes and that it was unpainted. On 10/28/24 at 1:31 PM the surveyor observed the area on the wall in room [ROOM NUMBER] had scrapes and was unpainted. On 10/29/24 at 9:23 AM the maintenance director (Staff #5) reported that staff usually put maintenance concerns into TELS (an electronic system to report and track maintenance issues) and that he checked the TELS twice a day and tried to fix as much as they could that particular day. The maintenance director reported he had a list of rooms that he was working on and indicated he would go get the list. At 9:28 AM the maintenance director confirmed that he had not identified any problems in room [ROOM NUMBER]. On 10/29/24 at 9:32 AM the surveyor and maintenance director observed the area with scrapes that was unpainted in room [ROOM NUMBER]. The maintenance director reported he could sand and repaint the area. 3) On 10/23/24 at 9:46 AM surveyor observed three areas on the walls of room [ROOM NUMBER]'s bathroom that had light color spackling where it appeared repairs had been completed but not painted. This included a large area of the wall across from the sink of approximately 6 inches x 24 inches. On 10/29/24 at 9:11 AM observation of room [ROOM NUMBER]'s bathroom again revealed the unpainted areas of spackling. Additionally, the surveyor noted what appeared to be approximately 10-20 small paint chips on the floor near the large area of spackling. During the interview on 10/29/24 at 9:23 AM, the maintenance director (Staff #5) reported after they completed repairs to walls they would then paint the walls. He also reported he started working at the facility in July 2024. (continued on next page)

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	10/30/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 9:40 AM upon observation of room [ROOM NUMBER]'s bathroom walls, the maintenance director indicated he had not completed the repairs to the walls and reported that the staff should have informed him. The maintenance director stated: can't fix what I don't know about. On 10/29/24 at 11:13 AM the surveyor reviewed the concern of staff failure to report items in need of repair to maintenance with the Director of Nursing.

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	10/30/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48168 Based on record review and interview, it was determined that the facility failed to ensure that residents were free of abuse. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 12/13/23. This was evident for 1 resident (Resident #296) of 6 residents reviewed for abuse during the recertification survey. The findings include: On 10/23/24 at 3:15 PM a review of the facility reported incident #MD00200167 revealed that on 12/03/23 when Geriatric Nursing Assistant (GNA #14) attempted to place Resident #296 into a wheelchair, GNA #14 grabbed the resident ' s hands and pulled and wrestled with the resident which resulted in bruises and bloody skin tears on the resident ' s hands. On 10/23/24 at 3:20 PM a review of the initial report to the Office of Health Care Quality (OHCQ) dated 12/03/23 at 7:45 PM, revealed that the incident occurred in the resident ' s room and that Resident #296 had skin tears on the right and left thumbs, and a skin tear on the top of his/her left hand. It further stated that the alleged perpetrator was suspended, treatment was ordered for the resident ' s injuries, and the resident ' s physician and family were notified. A review of the facility's investigation file included a statement dated 12/04/23 written by the Interim Director of Nursing (Staff #19) who interviewed Resident #296. The resident stated that GNA #14 pulled on his/her hands and the GNA stated I ' m in charge today. Further review of the same document revealed another witness statement from Resident #296 ' s roommate who observed GNA #14 as she wrestled with Resident #296 and stated that GNA #14 pushed and pulled on Resident #296 and made the resident sit in a chair. The roommate observed that both of Resident #296 ' s hands were bloody. On the same statement, handwritten notes indicated that the police were notified and a case number was included. Another handwritten notation on the same document was dated 12/05/23 which stated 1-2 weeks before police report ready and was signed by Staff #19. Further review of the investigation file revealed a nursing progress note written on 12/03/23 at 8:57 PM by Licensed Practical Nurse (LPN #22) that stated that the resident was observed to have three skin tears and multiple scattered dark bruises on both hands. The note included Resident #296 ' s description of the incident, that GNA #14 grabbed the resident ' s hands. The nurse wrote that she provided Resident #296 treatment for the skin tears and pain medication. In a handwritten witness statement written by LPN #22 she said that when she questioned GNA #14 about what happened and asked the GNA to write a statement, GNA #14 cursed loudly at LPN #22 and refused to write a statement. (continued on next page)

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	10/30/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility ' s final report to the Office of Health Care Quality (OHCQ) revealed a statement in the Conclusion section of the document that stated The allegation was verified by evidence collected during the investigation and interview with the victim and the victim ' s roommate. In the Corrective Action portion of the final report to OHCQ Staff #19 wrote that Employee (GNA #14) has remained suspended and will be terminated today. The incident will be reported to the nurse aide registry. A police report present in the facility ' s investigation file stated that the facility concluded that abuse (an assault) did occur. On 10/25/24 at 2:37 PM - a review of GNA #14 ' s employee file revealed that she had an active GNA license, a clear background check when hired, and that she received abuse training in May 2023. On 10/25/24 at 3:55 PM the Senior [NAME] President of Clinical Services (Staff #7) was interviewed regarding the incident and she provided evidence of steps taken following the incident. She further stated that no other incidents of abuse have occurred at the facility. The surveyor reviewed the evidence provided by Staff #7 and it demonstrated that the facility took the following actions after the incident, 1) abuse education was provided to all employees, 2) resident skin assessments and resident interviews were done daily x 2 weeks, then 2 times per week for 2 weeks, then monthly x 2 months and 3) the employee was immediately terminated on the day of the incident, 4) the GNA was reported to the nursing registry. Based on the above evidence it was determined that the date of compliance was 12/13/23.

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	10/30/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and interview with staff, it was determined that the facility failed to provide written notification of transfer to Residents and/or Resident representatives upon transfer to the hospital. This was evident for 1) one Resident (#59) of two residents reviewed for hospitalization and 2) one complaint (#MD001973041) of nine complaints reviewed during the recertification survey. The findings include: 1) A medical record review for Resident #59 on 10/23/24 at 9:52 AM showed that the Resident had difficulty breathing on 8/16/24. The attending provider was notified and ordered to send the Resident to the emergency room for evaluation. Further medical record review showed that Resident #59's representative was notified via phone. However, the review failed to show that the Resident and/or the Resident representative was notified in writing of the transfer and the reason for the transfer. In an interview on 10/25/24 at 12:13 PM, staff #11, a unit manager, stated that the staff notified Residents' representatives of hospital transfers via phone calls and not in writing. In an interview on 10/25/24 at 5:06 PM, the nursing home administrator was asked for evidence of written notification when Resident #59 was transferred to the acute care facility on 8/16/24. The NHA stated he had no evidence to show that a written notification was given to the Resident and/or his/her representative. 48168 2) On 10/23/24 at 11:45 AM a review of Resident #301's clinical record revealed that the resident was transferred to the emergency roiagnom on [DATE]. Further review of the medical record failed to reveal any evidence that a written notice of transfer was provided to the resident or the resident's representative. On 10/29/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted regarding Resident #301's transfer to the hospital. When asked to provide copies of the written notice of transfer the DON said that she was unable to find any such document in the resident's medical record and she confirmed that this was a deficiency.

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	10/30/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and interviews, it was determined that the facility failed to notify residents and/or their representatives in writing of the facility's bed hold policy upon transfer to an acute care facility. This was evident for 1) one Resident (#59) of 2 Residents reviewed for hospitalization s and 2) one complaint (#MD001973041) of 9 complaints reviewed during the recertification survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. 1) A record review for Resident #59 on 10/24/24 at 5:38 PM showed that the Resident had been living in the facility since November 2022 and had moderate cognitive impairment per an MDS assessment dated [DATE]. The continued review contained a nurse's note that Resident #59 was transferred to the hospital on 8/16/24 due to difficulty breathing. However, the review failed to show that a copy of the facility's bed hold policy was mailed to the Resident's representative. In an interview on 10/25/24 at 12:13 PM, staff #11, a unit manager, reported that residents' representatives were not notified of the facility's bed hold policy upon transfer of residents to the hospital because families sign the facility's bed hold policy upon residents' admission to the facility. In an interview on 10/25/24 at 4:08 PM, the director of nursing reported that the bed hold policy was typically discussed with residents or their representatives upon acute transfer to the hospital and not given in a written form. 48168 2) On 10/23/24 at 11:45 AM a review of Resident #301's clinical record revealed that the resident was transferred to the emergency roiagnom on [DATE]. Further review of the medical record failed to reveal any evidence that a written bed hold policy notice was provided to the resident or the resident's representative. On 10/29/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted regarding Resident #301's transfer to the hospital. When asked to provide copies of the written bed hold policy notice the DON said that she was unable to find any such document in the resident's medical record and she confirmed that this was a deficiency.

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	10/30/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to develop and implement a comprehensive, resident centered care plan for a resident receiving psychotropic medications. This was evident for 1 (#58) of 5 residents reviewed for unnecessary medications: The findings include: A 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. 1) On 10/23/2024 1:47 PM, a review of Resident #58's medical record revealed the resident was admitted to the facility in early October 2024 following an acute hospital stay. Review of Resident #58's admission assessment with an assessment reference date of 10/13/24 revealed the resident's BIMS (brief interview for mental status) summary score was 3, indicating the resident had severe cognitive impairment, and had diagnoses which included dementia, depression and adjustment disorder with mixed anxiety and depressed mood. Review of the resident's October 2024 Medication Administration Record revealed Resident #58 received psychotropic medication for depression. The resident had a 10/08/24 order for Fluoxetine (Prozac) (an antidepressant) 20 MG (milligrams) by mouth one time a day for depression, that was documented as given every day from 10/08/24 to 10/15/24, then discontinued on 10/16/24, and a 10/16/24 order for Fluoxetine 40 MG by mouth one time a day that was documented as given every day from 10/16 through 10/23/24. A review of Resident #58's care plans revealed a care plan focus, [Resident #58] uses antidepressant medication r/t depression, with the goal, [Resident #58] will be free from discomfort or adverse reactions related to antidepressant therapy through the review date, that had the interventions: 1. Administer antidepressant medications as ordered by physician. Observe for side effects and effectiveness, 2. Encourage to express feelings during interactions and observe for nonverbal signs of depression, 3. notify MD if concerned, refer to psych as needed, and 4. Observe PRN (as needed) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. The care plan goal addressed the resident's response to possible drug related complications related to the resident's use of the psychotropic medication for depression, however, continued review of Resident #58's care plans failed to reveal evidence that a comprehensive care plan had been developed with measurable goals and non-pharmaceutical interventions that addressed the resident's targeted symptoms for use of an antidepressant. On 10/24/24 at 12:30 PM, the above concerns were discussed with the Director of Nurses (DON) and the Senior [NAME] President of Clinical Services (Corporate Registered Nurse (RN)). The DON and Corporate Nurse acknowledged the concerns at that time.

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	10/30/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48259 Based on interviews and medical record review, it was determined that the facility failed to ensure participation in the care plan process by a resident's representative. This was evident for 1 (#89) of 2 residents reviewed for care planning. The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. Care plans are developed to guide residents' care in the facility. They must be created within 7 days of completion of a resident's admission comprehensive MDS assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team, including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable). Participation in care planning by a resident and Resident representative can take many forms, such as holding care planning conferences (meetings) when the resident representative is available to participate, conference calls, or videoconferencing. In an interview on 10/22/24 at 2:26 PM, Resident #89's representative reported that a formal meeting to discuss the Resident's care had not occurred since the Resident's admission to the facility. A medical record review on 10/24/24 at 5:10 PM showed that Resident #89 was admitted to the facility in June 2024. The review also noted that Resident #89's daughter was the decision maker for the Resident as s/he had severe cognitive impairment. The further review contained a care plan conference summary report dated 7/3/24 with a notation that Resident #89's representative was unable to participate but will reschedule a care plan meeting. However, the review failed to show that a care plan meeting was rescheduled to ensure Resident #89's representative's participation. Continued review showed that Resident #89's Admission MDS assessment was completed on 7/31/24. However, the review failed to show that a care plan meeting occurred following the completion of the Resident's MDS assessment. In an interview on 10/25/24 at 11:19 AM, staff #2, the social services director, reported that his staff updated Resident #89's care to his/her representative but not a care conference meeting. (continued on next page)

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	10/30/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/25/24 at 11:24 AM, staff #3, social service designee, reported that Resident #89's representative could not physically attend the care conference meeting, so it was done over the phone. However, staff #3 stated she did not have documentation to show that the meeting occurred or that she rescheduled the meeting as stated on the care conference summary report.

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	10/30/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48259 Based on observation, review of facility policy, and interview, it was determined that the facility staff failed to follow standards of professional practice when administering medications to residents. This was evident for 1 opportunity out of 26 opportunities observed for medication administration. The findings include: During observation of medication administration on 10/25/24 at 8:31 AM, the surveyor observed that Staff #4 prepared medications for Resident #70. Staff stated that the resident was out of Miralax powder, so she borrowed from Resident #73's medicine supply. A review of the facility's Medication administration-general guidelines policy showed that medications supplied for one resident are never administered to another resident. In an interview later that day, staff #4 reported that the medication she borrowed was a house-stock medication. However, she was out of supply and waiting for the facility's supply person to restock. In an interview on 10/25/24 at 3:22 PM, the director of nursing reported that the staff person in charge of restocking house medications was not at work that day. However, she expected staff #4 to get the key, restock the medication, and not borrow another resident's medication.

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	10/30/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 16218 Based on medical record review and interview it was determined that the facility failed to ensure discharge plans were appropriate for the resident's needs. This was found to be evident for one (Resident #72) out of three residents reviewed for discharge. The findings include: Review of Resident #72's medical record revealed the resident was admitted to the facility in September 2024 after a hospitalization for an infection. The resident received intravenous (IV) antibiotics, wound care, physical therapy (PT) and occupational therapy (OT) while at the facility. On 9/23/24 a care plan to discharge home was initiated. Review of the 10/15/24 attending medical provider's progress note revealed that the resident was being treated with two different IV antibiotics with an end date of 10/26/24 for the antibiotics. This note also documented that the resident would be going home on 10/21/24 with home PT, OT and wound care. Further review of the medical record revealed an interdisciplinary care plan conference was conducted on 10/15/24 with the resident, a family member, the unit nurse manager (Staff #9), the social worker (Staff #2) and the therapy director. This note indicated the plan was to discharge to the family member's home with HHC [home health care] and that the resident and family were agreeable to first available provider. A review of the Social Service Review note dated 10/17/24 revealed in the Referral Status section that referrals were made to [Agency A] for home health services and to [Agency B] for antibiotic home infusion (IV antibiotics). A review of the 10/17/24 Social Service Progress note, written by Social Worker (Staff #2) revealed that the resident was to be discharged on Monday 10/21/24 with home healthcare services through [Agency A] and home infusion services through [Agency B]. A review of the Discharge Planning Review note, revealed it was signed by the resident (no date next to resident signature), the SW (Staff #2) on 10/17/24 and the unit nurse manager (Staff #9) on 10/18/24. The note included documentation that referrals had been made to [Agency A] and [Agency B]. Further review of this document failed to reveal phone numbers or contact information for either [Agency A] or [Agency B]. A review of a Discharge Summary progress note written by the unit nurse manager (Staff #9) on 10/21/24 revealed the Discharge Packet was reviewed and signed by the resident. During an interview with the unit nurse manager (Staff #9) on 10/29/24 at 4:06 PM, she confirmed that just the Discharge Planning Review document is provided at the time of discharge and that no additional documentation regarding the home health agencies was provided. (continued on next page)

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	10/30/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 a review of the Social Service Progress Note, dated 10/23/24 at 3:02 PM, revealed that the Social Worker had received a call from the resident's family member that day and informed him that the IV antibiotic provider [Agency B] had not followed up with them and that [Agency A] had reported that they had not received the referral for services. The Social Worker then contacted [Agency B] about a faxed referral to which [Agency B] staff informed the Social Worker that they no longer provide IV antibiotic services. This note also indicated SW attempted to contact the admission liaison at [Agency A]. On 10/28/24 at 12:45 PM the Social Worker (Staff #2) was interviewed about the discharge planning process. The Social Worker reported discharge planning starts with the initial baseline care plan. In regards to setting up home health services he reported he checked insurance coverage and presented choices, then contacted the agency and faxed over history and physical, medications, orders, and identified a start of care date. In regard to Resident #72 the Social Worker reported he sent the referral to [Agency A] and called [Agency B] for the IV infusion. When asked for clarification if he spoke with anyone at either [Agency A] or [Agency B], the Social Worker reported he spoke with [Agency A] earlier in the week and asked if they could do infusion and that he faxed them on Friday but they did not follow up with him. On 10/28/24 at 1:02 PM the Social Worker presented documentation that indicated 26 pages of documentation was faxed to [Agency A] and to [Agency B] on 10/17/24. The surveyor reviewed the concern with the Social Worker that the documentation indicated the only contact with either of these agencies in regard to Resident #72's discharge was the faxes. On 10/29/24 at 1:33 PM the Social Worker confirmed there was no documentation to indicate he discussed Resident #72 with [Agency A]. On 10/29/24 at 11:10 AM the surveyor reviewed the concern with the Director of Nursing that the Social Worker had failed to confirm the arrangements with two of the home health providers prior to the resident's discharge. Further review of the medical record revealed a Social Service Progress note, dated 10/23/24 at 3:34 PM, which revealed the Social Worker spoke with staff at two new home health agencies, [Agency C] and [Agency D], to arrange for IV antibiotics and home health care. The note indicated that the social worker faxed and e-mailed referral materials to liaisons on 10/23/24. The documented plan was for IV antibiotics thru [Agency C] with a start date of 10/24/24 and Home Health Care through [Agency D] on 10/25/24.

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	10/30/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45139 Based on record review, observations and interviews, it was determined the facility failed to implement physician ordered pressure injury prevention therapies. This was evident for 1 (Resident #77), out of 2 residents reviewed for pressure injuries during a survey. The findings include: On 10/22/24, the medical records of Resident # 77, a long-term resident of the facility, were reviewed. The review revealed that the resident had a recently healed pressure injury on his/her heel. On 10/24/24 at 9:07 AM a review of Resident #77's physicians orders revealed the following: 1) Order dated 8/06/24, for the resident to wear protector boots while in bed for skin integrity to heels. Can be removed for ADL (activities of daily living) care, observing skin and administering treatment. Re-apply heel protector boots afterwards, when in bed. Every shift for skin integrity. 2) Order dated 7/21/24, to Float heels when in bed qs (every shift) for skin breakdown. On 10/25/24 at 2:02PM a review of Resident #77's care plan revealed a skin integrity care plan. Further review revealed a therapeutic intervention for the resident to wear Heel Medix boots to bilateral (both) feet as resident allowed. The following observations were made during the survey: On 10/22/24 at 3:46 PM, Resident # 77 was observed lying in bed with his/her heels resting against the bed linens. No heel protectors were observed. On 10/25/24 at 7:50 AM, Resident # 77 was observed lying in bed with his/her heels resting against the bed linens. No heel protectors were observed. On 10/25/24 at 8:59 AM, Resident # 77 was observed sitting up in bed. Further observations revealed a thin pillow under the resident legs and her/his heals resting against the linens. Observation failed to reveal the resident wearing boot heel protectors. On 10/25/24 at 10:06 AM, Resident # 77 was observed sitting up in bed with a thin pillow under his/her legs. Continued observation revealed the resident's legs were moving, and his/her heels rubbing against the linens. Observation failed to reveal the resident wearing boot heel protectors. On 10/25/24 at 11:36 AM, Resident #77 was observed lying in bed. Observation failed to reveal the resident wearing heel booties. Continued observations revealed a blue wedge on the floor and a thin pillow or bolster, lying beside it. Observation failed to reveal the resident wearing boot heel protectors. On 10/25/24 at 12:30 PM Resident #77 was observed lying in his/her bed. The observation failed to reveal the resident wearing heel protector booties. (continued on next page)

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	10/30/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 2:30 PM observation of resident #77 in new room. Resident lying in bed, thick bolster pillows elevating the heels of the bed linens. Further observation failed to reveal the resident wearing heel protector booties. On 10/25/24 at 2:32 PM in an interview with GNA (Staff #17), she reported that she provided care to Resident #77. She reported that Resident #77 often refused to wear booties. An observation of the resident's room with the GNA failed to reveal any heel protector booties in the residents room. On 10/25/24 at 2:40 PM, during an interview with the South Unit Nurse Manager (Staff #11), she confirmed that the resident did not wear heel booties during day shift on 10/25/24. She reported that when the resident was moved to a different room, she noted that the booties were on the resident's floor. She instructed her staff to send the booties to the Laundry to be cleaned for infection prevention. On 10/25/24 at 2:49 PM, the Wound Nurse RN (Staff # 18) was interviewed. During the interview she reported that most of the residents in the unit wore the same type of heel protection booties. She reported the facility always had heel protection booties available for the residents, that used the standard booties. When a resident's heel protection booties were sent to the laundry, replacement booties were obtained from the clean utility closet by the nursing staff. On 10/25/24 at 4:08 PM, the above concern was discussed with the South unit manager nurse (RN, Staff #11), who said she thought that the boots were labeled, and that the laundry staff would bring back the booties, with the resident's clothes. She reported there was a miscommunication to ensure that the booties were used for the resident. On 10/29/24, the facility provided a facility policy titled Pressure Injury and Prevention Guidelines. A review of the policy revealed a statement that compliance with the interventions would be documented in the medical record. On 10/25/24 at 8:43 AM, the Physician (Staff #9) who provided wound care services to the facility, was interviewed. During the interview he reported that the expectations were that if a resident was not compliant with the recommendations for prevention measures it should be documented in the medical record. On 10/25/24 at 4:30 PM, a review of Resident #77's progress notes from 10/22/24 through 10/02/24 failed to reveal documentation that the resident refused to wear the heel protector booties. On 10/30/24 at 7:46 AM the above concerns were discussed with the Director of Nursing and the [NAME] president of Clinical Services (Staff #11) and they both confirmed the concerns. No additional information was provided prior to the end of the survey.

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	10/30/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 45139 Based on surveyor observation, review of clinical records and interview of facility staff, it was determined that the facility staff failed to provide treatment to maintain an individual's range of motion. This was evident for 1 (Resident #80) out of 2 residents selected for position and mobility, during a survey. The findings include: On 10/23/24 at 10:00 AM, review of Resident #80's medical record revealed that the resident was a long-term resident of the facility and due to physical and cognitive limitations s/he was totally dependent on the assistance of staff for her/his activities of daily living. On 10/23/24 at 10:40 AM a review of the resident's physician orders revealed an order dated 2/10/24, Pt will wear bilateral wrist/hand brace/splint for up to 6 hours or as tolerated to reduce risk of further contracture. Skin integrity checks pre/post wear, every day and evening shift. A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. On 10/29/24 at 3:20 PM Occupational Therapist (Staff #12) was interviewed. During the interview she reported that she recommended the brace/splint for Resident #80. She reported that purpose of the brace/splint was to maintain the hand in correct alignment and prevent Resident #80's finger contractures from getting worse and injuring the residents had. The following observations were made during the survey: On 10/22/24 at 9:24 AM, an observation was made of Resident #80's room. Observation revealed Resident #80 lying in bed. The observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. Further observation revealed that Resident #80 was asleep, and his/her hands were closed in a fist. On 10/23/24 at 11:14 AM, an observation of Resident # 80 revealed the resident asleep in bed. The observation failed to reveal that Resident #80 wore a bilateral wrist/hand splint. Further observation revealed that Resident #80's hands were closed in a fist. On 10/23/24 at 3:35 PM an observation of Resident #80 revealed the resident was seated in a high back reclining wheelchair. The observation failed to reveal that Resident #80 wore a bilateral wrist/hand splint. Further observation revealed resident her/his hands were closed in a fist. On 10/24/24 at 8:59 AM, an observation made of Resident #80 failed to reveal that s/he wore a bilateral wrist/hand splint. Further observation revealed resident her/his hands closed in a fist. (continued on next page)

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	10/30/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 11:32 AM an observation of Resident #80 revealed the resident lying in bed. The observation failed to reveal that Resident #80 wore a bilateral wrist/hand splint. On 10/24/24 at 11:56 AM an observation of Resident #80 revealed the resident lying in bed with only the left arm was laying outside the blanket and visible. The observation failed to reveal that the resident wore a wrist/hand splint on the left hand. Further observation revealed that the resident's left hand was closed in a tight fist. On 10/24/24 at 12:40 PM an observation of Resident #80 revealed the resident lying in bed with only the left arm was laying outside the blanket and visible. The observation failed to reveal that the resident wore a wrist/hand splint on the left hand. Further observation revealed that the resident left hand was closed in a tight fist. On 10/24/24 at 2:27 PM an observation of Resident #80 revealed the resident was seated in a high back reclining wheelchair. The observation failed to reveal that Resident #80 wore a bilateral wrist/hand splint. Further observation revealed resident hands closed in a fist. On 10/24/24 at 4:12 PM an observation of Resident #80 revealed the resident wore a blue soft splint on the right- and left-hand wrist. On 0/24/24 at 4:21 PM the South Unit Nurse Manager (Staff #11) was interviewed. Staff #11 confirmed the concerns with the brace/splints not being applied to the resident during the observations listed above. In addition, she confirmed that the treatment administration record (TAR) documented that the resident wore the bilateral brace and splints during the day shift on 10/23/24 and 10/24/24, which was inconsistent with surveyor observation listed above. She reported that she did conduct splint audits, and she would educate her staff and ensure the documentation on TAR was accurate.

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	10/30/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 51213 Based on observation, medical record review and interviews, it was determined that the facility failed to 1) ensure that as needed pain medication orders included pain scale parameters for administration and 2) document pain assessment to include the location of the pain and type of pain for a Resident reporting pain. This was evident for 2 (#25, #89) of 2 residents reviewed for pain management. The findings include: A pain scale is a numerical scale, usually 1-10, used to rate a person's severity of pain. 1) On 10/23/24 at 10:57 AM Resident #25 was observed lying in bed fully dressed with a grimace on his/her face. Resident #25 stated he/she just had his/ her dressing changed, and the nurse went to get some pain medication. On 10/24/24 at 8:39 AM Resident #25's medication orders were reviewed. It revealed a physician order dated 6/18/24 for Acetaminophen (Tylenol - a non-narcotic) 325 mg tablets 2 tablets by mouth every 6 hours as needed for mild pain: moderate pain. Further review of the Medication Administration Record (MAR) revealed another as needed pain medication order dated 6/18/24 for Oxycodone (a narcotic) one 5 mg tablet by mouth every 6 hours as needed. Further review of the MAR failed to reveal a pain scale to determine at what pain level each medication should be administered. On 10/24/24 at 10:00 AM Licensed Practical Nurse (LPN #4) was interviewed and asked how she knew when to give Resident #25 as needed medications. LPN #4 stated that Resident #25 would ask for pain medication and that when his/her pain level was 6, he/she asked for Oxycodone instead of Tylenol. LPN #4 was asked if the order for Oxycodone stated at what pain level the medication should be given and she said no, there was no associated instruction other than to give for pain. On 10/24/24 at 12:10 PM the Director of Nursing (DON) and Senior [NAME] President of Clinical Services (Staff # 7) were interviewed. The DON was asked if it was her expectation that there should be parameters for pain medications and she responded yes. The DON was made aware that Resident #25 had no pain scale parameter ordered for the as needed Oxycodone. The DON and Staff #7 acknowledged that the as needed Oxycodone order should have included a pain scale. 48259 2) During the initial tour of the memory care unit on 10/22/24 at approximately 10:00 AM, Resident #89 was observed in the activity area with staff and other residents and saying, Can you help me? I have pain; my back is killing me?. A subsequent observation was made on 10/24/24 at 1:13 PM of Resident #89 in the hallway saying, My back is killing me, with staff #26, a licensed practical nurse, standing close by the Resident. A review of Resident #89's medical record showed that the Resident was admitted to the facility in June 2024 with diagnoses including a history of right hip pain and usually able to communicate needs. (continued on next page)

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	10/30/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continued review of Resident 89's medication administration record for October 2024 showed that s/he had received pain medication on 10/23/2024 at 12:39 and 10/23/2024 at 23:10 and a follow-up pain scale of 0 for both dates. However, the review failed to show a record of Resident #89's pain assessment, including the location, type of pain, and non-pharmacological interventions (NPI- are interventions without medications) implemented before administering pain medicine. In an interview on 10/24/24 at 1:14 PM, staff #26, a licensed practical nurse, reported that she implemented NPI only when the Resident continued to complain of pain after the PRN (as needed) medicine was administered. In an interview on 10/24/24 at 1:26 PM, the regional director of clinical services said that nurses were expected to record what NPI they implemented before administering PRN pain medicines to residents. She also stated that she expected nurses to document their assessment of residents' pain in the medical record, including the location and type of pain, before and after administering PRN pain medications.

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	10/30/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 16218 Based on review of pertinent documentation and interview it was determined that the facility failed to ensure two staff members completed the controlled drug count at the change of each shift. This was found to be evident for one out of three drug control books reviewed during the survey. The findings include: A review of the facility's Controlled Substance Storage policy, with a revision date of March 2017, revealed the following statement: At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented. A review of the Shift Count documentation revealed columns in which nursing staff would document the date, time of day, if the count was correct (Yes or No), signature of Coming On Duty Nurse and the signature of Going Off Duty Nurse. On 10/28/24 at 1:39 PM nurse (Staff #16) confirmed that they sign the Shift Count form when the count is completed. A review of the Shift Count documentation for the Section 1 North medication cart on 10/28/24 at 1:35 PM revealed documentation that a shift count was completed on 10/28/24 at 7:00 AM and was signed by the Coming on Duty Nurse (Staff #8) and the Going Off Duty Nurse. Further review revealed that in the next row of this document, Staff #8 had already signed as the Going off Duty Nurse, all of the other columns in this row were blank at the time of the review, which indicated that no count had occurred. On 10/28/24 at 2:03 PM the surveyor reviewed the pre-signed shift count documentation with the unit nurse manager (Staff #9). The nurse (Staff #8) was then interviewed, in the presence of the unit nurse manager. Staff #8 confirmed her signature on the Shift Count sheet as the Going Off Duty nurse and indicated this was her standard practice. She went on to report this was how she was instructed to sign the Shift Count, at this point in the interview the unit manager intervened and instructed the nurse (Staff #8) that she should sign the Shift Count at the time of the count. On 10/29/24 at approximately 11:00 AM further review of the Shift Count documentation for the Section 1 North medication cart failed to reveal a signature to indicate the Nurse Going Off Duty on 10/24/24 at 11:00 PM had completed the count with the Coming On Duty nurse. On 10/29/24 at 11:10 AM surveyor reviewed the concern with the Director of Nursing (DON)regarding staff pre-signing the shift count. The DON was also informed that further review of the shift count sheet failed to reveal a signature for the offgoing nurse for 10/24/24 at 11:00 PM.

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	10/30/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48259 Based on medical record review and staff interview, it was determined that the facility failed to document the specific reason for administering a psychotropic medication prescribed as needed (PRN) and failed to implement non-pharmacological intervention before administering the medicine. This was evident for 1 complaint (#MD00192471) of 9 complaints reviewed during the recertification survey. The findings include: Non-pharmacological interventions (NPI) are interventions without medications. A review of complaint #MD00192471 revealed an allegation that Resident #299 was chemically restrained with the use of an antianxiety medication. A record review for Resident #299 showed an attending provider's orders dated 9/30/22 to 10/4/22 and 10/4/22 to 10/11/22 for antianxiety medication to be administered to Resident #299 every 12 hours PRN for agitation/anxiety. A review of Resident #299's medication administration record (MAR)for September and October 2022 was completed. The MAR had recorded that the nurses administered the antianxiety medication to Resident #299 on 9/30/22 with a post-medication assessment that stated: ineffective. The Resident also received the antianxiety medication on 10/8/22 and 10/9/22, and the post-medication assessment for both days stated: ineffective. The continued review contained an antianxiety medication count sheet for Resident #299 that recorded that staff had administered the medication to the Resident on 10/6/22 at 8:00 PM and 10/8/22 at 9:00 PM. However, the review failed to show the specific behaviors for which the antianxiety medication was administered, NPI attempted before administering the medicine, what interventions were implemented when the post-medication assessments stated ineffective, ongoing monitoring of the Resident's behaviors and side effects related to the use of the medication. In an interview on 10/29/24 at 3:17 PM, the director of nursing confirmed concerns and stated, I understand your concerns.

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	10/30/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45139 Based on observation and interview, it was determined that the facility failed to ensure medications and needles were secured as evidenced by observations of unlocked emergency carts in residents' hallways. This was evident for 2 emergency carts out of 2 emergency carts observed during a survey. The findings include: On 28/24/24 at 10:42 AM, an observation was made of the emergency cart located in the South Unit, near the nurse's station. Observation revealed the lower drawer of emergency cart was slightly opened. Further observation of the emergency care revealed the emergency cart was not locked. Continued observation revealed the top drawer opened. An observation of the top drawer revealed 1 amp of 1.10.00 epinephrine (a medication that is injected into the veins during a cardiac arrest) and a glucagon syringe, (a medication used to increase circulating blood sugar when a residents blood sugar is too low.) On 2/28/24 at 10:44 AM, an observation of the second emergency cart on the North Unit was made, with the Director of Nursing. The observation revealed the emergency cart was unlocked and 4 needles used to start infusions were unsecured in the third drawer. On 10/28/24 at 10:47 AM, an observation of the south emergency cart with the Director of Nursing, (DON) was made. During the observation she confirmed the emergency cart was unlocked and the amp of epinephrine and glycogen were unsecured. 10/28/24 at 01:36 PM, during an interview, nurse (RN, staff #18) reported that the emergency cart is not kept locked, and that night shift stocks that cart. On 10/29/24 at 3:56 PM, the above concerns were discussed with the Director of Nursing. She reported that the emergency carts have been moved behind locked doors and she understood the concerns with medications not being secured. In addition, she reported the facility did not have a policy pertaining to the facility's emergency carts.

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	10/30/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on surveyor observation and staff interview, it was determined that the facility staff failed to properly store food items in the kitchen's walk-in refrigerator, and failed to properly label, and date food items stored in the main kitchen. This was evident during the initial tour of the kitchen and had the potential to affect all residents. The findings include: On [DATE] at 8:40 AM, accompanied Staff #10, Dietary Manager, an observation was made of the Kitchen. An observation of the kitchen's walk-in refrigerator revealed: - An opened 46-ounce container of thickened Ready Care lemon Water that was not labeled with date opened. - An opened 8-quart plastic facility container with approximately 2 quarts of Applesauce not labeled with date food was placed in the container. - An opened 8-quart plastic container with approximately 2 quarts of fruit cocktail not labeled with date food was placed in the container. - An opened container of gravy labeled with date [DATE]. At that time, Staff #10 indicated the gravy container was labeled with the wrong date. - An opened container of Thick and Easy nectar thick beverage dated [DATE] that was expired. - An opened container of Thick and Easy honey thick beverage dated [DATE] that was expired. Per the manufacturer, Thick and Easy beverages should be refrigerated after opening and used within 14 days. An observation of the kitchen's dry storage room revealed : - 1 6-pound (lb) 9-ounce (oz) container of Mandarin oranges that was not dated when received. - 3 6.75 lb cans of chili con carne that were not dated when received. - 1 6.6 lb can of sliced white potatoes that was not dated when received. - 6 8 lb cans of concord grape jelly that were not dated when received. - 2 6.56 lb cans of carrots that was not dated when received. - 1 opened bag of hamburger buns that was not dated when opened. (continued on next page)

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	10/30/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1 opened bag of hot dog buns that was not dated when opened. Staff #10 was present during the observation of the dry storage room and confirmed the findings at that time. On [DATE] at 5:20 PM, the Nursing Home Administrator (NHA) was made aware of identified concerns with food storage and the NHA acknowledged the concerns at that time.

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	10/30/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45139 Based on observation and medical record review it was determined that the facility failed to ensure that the staff only documented interventions that were completed. This was evident for 1 (Resident # 80) out of 35 Resident reviewed during a survey. The findings include: On 10/23/24 at 10: AM, review of Resident #80's, a long-term resident of the facility, medical record revealed that due to physical and cognitive limitations s/he was totally dependent on the assistance of staff for her/his activities of daily living. On 10/23/24 at 10:40 AM, review of orders revealed an order with a start date of 2/10/24, Pt will wear bilateral wrist/hand brace/splint for up to 6 hours or as tolerated to reduce risk of further contracture. Skin integrity checks pre/post wear every day and evening shift. The following observations were made during the survey: On 10/22/24 at 9:24 AM, an observation was made of Resident #80's room. Observation revealed Resident #80 lying in bed. The observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. Further observation revealed that Resident #80 was asleep, and his/her hands were closed in a fist. On 10/23/24 at 11:14 AM, an observation of Resident # 80 revealed resident asleep in bed. Observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. Further observation revealed that Resident #80's hands were closed in a fist. On 10/23/24 at 3:35 PM, an observation of Resident #80 revealed the resident was sitting up in a high back reclining wheelchair. The observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. Further observation revealed resident her/his hands closed in a fist. On 10/24/24 at 8:59 AM, an observation made of Resident #80 failed to reveal that she/he was wearing a bilateral wrist/hand splint. Further observation revealed resident her/his hands closed in a fist. On 10/24/24 at 11:32 AM, an Observation of Resident #80 revealed the resident lying in bed. The observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. On 10/24/24 at 11:56 AM, an observation of Resident #80 revealed the resident lying in bed with only the left arm was laying outside the blanket and visible. The observation failed to reveal that the resident was wearing a wrist/hand splint on the left hand. Further observation revealed that the resident left hand was closed in a tight fist. (continued on next page)

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	10/30/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 12:40 PM, an observation of Resident #80 revealed the resident lying in bed with only the left arm was laying outside the blanket and visible. The observation failed to reveal that the resident was wearing a wrist/hand splint on the left hand. Further observation revealed that the resident left hand was closed in a tight fist. On 10/24/24 at 2:27 PM, an observation of Resident #80 revealed the resident was sitting up in a high back reclining wheelchair. The observation failed to reveal that Resident #80 was wearing a bilateral wrist/hand splint. Further observation revealed resident hands closed in a fist. On 10/24/24 04:12 PM, an observation of Resident #80 revealed the resident was wearing a blue soft splint on the right and left hand/wrist. On 10/24/24 at 12:34 PM, The treatment administrative record (TAR) for Resident # 80 was reviewed. The review revealed there was a place to record if the splint/brace was applied on every day and every evening sift. Further review of the TAR revealed that the resident wore the splint/brace during day shift 10/23/24 and 10/24/24 which was inconsistent with the observations listed above. On 0/24/24 at 4:21 PM, The South Unit Nurse Manager (Staff #11) was interviewed. Staff #11 confirmed the concerns with the brace/splints not being applied to the resident during the observation listed above. In addition, she confirmed that the treatment administration record documented that the resident wore the bilateral brace and splints during the day shift on 10/23/24 and 10/24/24. 10/30/24 07:46 AM, the Surveyor discussed all concern with the Director of Nursing. No additional information was provided prior to the end of the survey.

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	10/30/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37276 Based on observation and staff interview, it was determined the facility failed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections by failing to ensure residents drinkware was clean. This was evident on 2 of 2 observations of drinkware designated for resident use. The findings include: On 10/25/24 at 8:40 AM, during an observation of the kitchen by 2 surveyors, 11 plastic mugs were observed upside down on a tray on a food cart located next to the door that exited into the dining room. At that time, Staff #12, Dietary Aide, indicated the coffee mugs were clean and were to be used for resident beverages. An observation of the inside of the coffee mugs revealed that 2 of the mugs had a chalky white/gray film, which was easily removed with gentle finger rubbing. Staff #12 confirmed the observation and removed the soiled mugs at that time. On 10/25/24 at 12:30 PM, an observation of the South Wing hallway revealed a food cart near resident rooms that had 2 trays of upside-down plastic mugs. On one of the trays were 11 mugs. Observation of the inside of the coffee mugs revealed 2 of the mugs had a chalky white/gray film, which was easily removed with gentle finger rubbing. Staff #11, RN (Registered Nurse), South Wing Unit Manager confirmed the observation. The observation of the soiled mugs was confirmed by Staff #11, RN (Registered Nurse), South Wing Unit Manager, who removed the mugs at that time, and stated s/he would bring the soiled mugs to the kitchen and make them aware of the concern. 10/25/24 at 5:20 PM, the Nursing Home Administrator was made aware of identified concerns with Infection control, and the NHA verbalized understanding of the concerns at that time.