STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview it was determined that the facility failed to ensure that residents were treated with respect and dignity. This was evident for one resident (Resident #81), and three residents (Resident #68, #48, #110) of 4 residents reviewed for dignity 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) During an initial tour of the Memory Care Unit on 2/17/26 at 8:59 AM, Resident #81 was observed to have finished breakfast. The Resident's blouse and pants were soiled with food particles, and the Resident was pacing up and down the hallway. Continued observation of Resident #81 noted facial hair on the Resident's chin and upper lip. In another observation on 2/17/26 at 1:53 PM, Resident #81 had finished eating lunch. The Resident was lying in bed, resting. His/her blouse remained soiled with food particles, and his/her lips were covered with a brown substance. Facial hair remained on the resident's upper lip and chin. A record review for Resident #81 included an MDS assessment dated [DATE]. The MDS noted that Resident #81 had severely impaired cognition and was totally dependent on staff for most self-care needs, including personal hygiene. During an interview on 2/17/26 at approximately 1:58 PM, Staff #27, a geriatric nurse aid (GNA), was with the surveyor in Resident #81's room. Staff #27 confirmed that the Resident's pants and blouse were soiled with food and that food residue was present on the Resident's lips. Staff #27 stated that he would immediately shave the Resident, clean the Resident's lips, and change the Resident's clothes. During an interview on 2/18/26 at 7:56 AM, Staff #27 reported that he shaved, cleaned, and changed Resident #81's clothing after the surveyor's intervention. 2a.) Resident #68 was admitted to the facility for care due to physical decline caused in part, by Parkinson's disease. The resident had a limited range of motion and was dependent on others for all care, which included the need to be fed. On 2/17/26 at 1:26 PM an unidentified staff nurse accompanied the surveyor to Resident #68's room to check on the resident, who resided in the bed closest to the door. When the nurse opened the door, a Geriatric Nursing Assistant (Staff #10) was observed as he stood next to the resident's bed and fed the resident lunch. The resident was alert and made eye contact with the surveyor but did not speak. (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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NAME OF PROVIDER OR SUPPLIER: Frederick Crossing of Journey		STREET ADDRESS, CITY, STATE, ZIP CODE: 30 North Place, Frederick, MD 21701	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no chair near the resident's bed. Staff remained standing during the observation. No attempt was made to find a chair to sit on, and no chair was observed near the bed. On 2/19/26 at 12:03 PM an interview was conducted with the Nursing Home Administrator (NHA) to review the observation that Staff #10 was observed as he stood over Resident #68 and fed them. The NHA said that one of the staff had also made that observation and reported it to him before the surveyor mentioned it. The NHA confirmed and acknowledged the deficiency and said he was disappointed because it was his practice to educate and encourage staff frequently regarding providing care with dignity. 2b.) On 2/17/26 at 1:36 PM, during the surveyor's interview with Resident #48, Staff #5, a Geriatric Nursing Assistant, failed to knock or ask permission to enter the resident's room before he entered the resident's room where the surveyor was speaking with Resident #48. Staff #5 also failed to identify himself or announce his intended purpose. Staff #5 was observed wearing headphone ear pieces as they proceeded to enter the room and removed both Resident #48 and Resident #48's roommate's meal trays and exited the room. Resident #48 confirmed to the surveyor that this was a normal occurrence. 2.c.) An observation on 2/18/26 at 8:32 AM showed that while Resident #110 was eating breakfast in his/her room, staff #28, a phlebotomist, entered the Resident's room and said, I'm here to draw your blood. The resident asked, Who sent you? and staff #28 responded, Your attending provider. Staff #28 then took the Resident's left hand and began preparing it to draw blood. The observation failed to show that Staff #28 knocked on the Resident's door, requested permission to enter the room and draw the blood, and introduced herself before drawing the blood. During an interview on 2/18/26 at 8:34 AM, staff #28 verbalized understanding of the concern regarding not knocking on the Resident's door and asking for permission before entering, not introducing herself, and not asking the Resident for permission before providing services. Staff #28 said she should have slowed down, not rushed, knocked, and introduced herself before drawing Resident #110's blood.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, it was determined that the facility failed to ensure information to formulate an advanced directive was provided to a resident. This was evident for 1 (Resident #39) of 1 resident reviewed for advanced directives. The findings include:Resident #39 was admitted into the facility in late 2025. A review of the resident's medical record on 2/18/26 at 12:16 PM revealed a certification from the attending physician dated 12/12/25 that indicated the resident was able to comprehend information and make decisions. A social services admission evaluation dated 12/15/25 by social services designee (Staff #3) indicated that a copy of the resident's advanced directive was requested.Further review of Resident #39's medical records failed to show a copy of the resident's advanced directives and there was no documentation to indicate that information was provided to the resident to formulate one. In an interview with Staff #3 on 2/19/26 at 11:43 AM, she explained the social services department's process with advanced directives. She noted that usually within 72 hours from admission, She or her colleague (Staff #19 who was also present during the interview) conducts an evaluation that includes discussion of the advanced directives, if they confirm that the resident has the capacity to comprehend information and make decisions.A review of Resident #39's medical record was conducted with Staff #3 on 2/19/26 at 11:53 AM. Staff #3 confirmed that she requested for a copy of the advanced directive on 12/15/25, however the resident still had not provided the facility a copy and there was no documentation to indicate that a follow-up had been made. Both social services designees (Staff #3 and Staff #19) indicated that the resident currently does not have the capacity to formulate a new advanced directive but that s/he had a power of attorney (POA) on file. However, after continued review of the resident's medical records, the POA on file was a financial POA and did not cover the resident's healthcare preferences.The concern was discussed with both staff that there was no documentation to indicate that a follow up was made to acquire a copy of the advanced directive and/or information was provided to the resident to formulate an advanced directive while s/he was deemed capable of understanding and making decisions. Both staff verbalized understanding and acknowledged the concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to notify residents of their potential financial liability when they were discharged from skilled care. This was evident for one resident (Resident #119) of 3 residents reviewed for beneficiary notification during the recertification survey.The findings include:Resident #119 was admitted to the facility on [DATE] for skilled care.On 2/18/26 a request was made for a list of residents who were discharged from skilled care in the past 6 months, and to include their disposition (whether they returned home or remained in the facility). On 2/19/26 at 10:00 AM a review of the list of residents discharged from skilled care was conducted. Three residents were randomly selected from the list, and the Nursing Home Administrator (NHA) was asked to provide the Notice of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) forms that were provided to those residents.On 2/19/26 at 12:15 PM a review of the documents provided was conducted and revealed that Resident #119 was provided with a NOMNC that indicated that their last covered Part A day was 9/03/25, and that the facility initiated the discharge from Part A Services when benefit days were not exhausted. No ABN form was provided for Resident #119.On 2/19/26 at 12:58 PM Resident #119's documents were reviewed with the NHA and Business Office Manager, Staff #21. When they were asked if the resident should have had an ABN provided, Staff #21 said yes, and they both confirmed that there was no evidence that an ABN was provided and there should have been.On 2/23/26 at 12:41 PM, in an interview with the NHA, he again confirmed the deficiency and said there was no other evidence to provide.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to complete Significant Change in Status Minimum Data Set (MDS) assessments within 14 days following a significant decline in the Residents' condition. This was evident in 2 (Resident #94 and #4) of 47 residents 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 on the MDS drives Resident care planning decisions. The nursing home should complete a Significant Change in Status MDS assessment within 14 days of a major decline or improvement in a resident's status after the determination that a significant change has occurred.1) A record review on 2/17/26 at 3:12 PM for Resident #94 included a progress note dated 9/7/25 by staff #11, unit manager, indicating that the Resident was admitted to hospice care effective 9/6/25 due to overall general decline.Further review included a Significant Change in Status MDS assessment dated [DATE] for Resident #94. The MDS assessment was completed and signed in sections Z0500B and V0200B2 on 9/29/25, 23 days after admission to hospice care and 9 days late.In an interview on 2/23/26 at 1:40 PM with staff #30, an MDS coordinator stated that admission to hospice care required completion of a Significant Change in Status MDS for any resident, and that the determination date was the day of admission to hospice care. Staff #30 confirmed that the Significant Change in Status MDS assessment for Resident #94, dated 9/16/25, was completed late.2) A record review for Resident #4 on 2/23/26 at 1:03 PM noted that the Resident was admitted to hospice services for failure to thrive, effective 11/10/25.A continued review of Resident #4's record included a Significant Change in Status MDS assessment dated [DATE]. The MDS assessment was completed and signed in sections Z0500B and V0200B2 on 12/2/25. During an interview on 2/23/26 at 1:45 PM, Staff #30 stated that the determination date for Resident #4's Significant Change in Status was 11/10/25, the date of admission to hospice services. However, an earlier review showed that Resident #4's Significant Change in Status MDS assessment, dated 11/20/25, was completed and signed in sections Z0500B and V0200B2 on 12/2/25, 22 days after admission to hospice care and 8 days late.Staff #30 confirmed that Resident 4's Significant Change in Status MDS assessment was completed late.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure that a resident's Minimum Data Set (MDS) assessment was accurately recorded. This was evident in 1 (Resident #81) of 3 residents reviewed for PASSR.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information about each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments must be accurate to ensure each resident receives the care they need.Preadmission Screening and Resident Review (PASRR) is a federal requirement that helps ensure individuals are not inappropriately placed in nursing facilities for long-term care. Individuals who test positive at Level I are referred to the local health department (LHD), where they receive an in-depth Level II PASRR evaluation.A medical record review on 2/18/26 at 1:07 PM for Resident #81 included a PASSR Level II evaluation report indicating a positive result due to a history of developmental delay. A subsequent review showed a care plan initiated on 4/26/23 stating that Resident #81 had a Positive PASSR due to developmental delay.However, further review of an MDS assessment dated [DATE] for Resident #81 showed that it recorded a no in section A1500 to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?During an interview on 2/20/26 at 12:19 PM, staff #3, a social service designee, reported that Resident #81 was evaluated as having a positive PASSR II due to a history of developmental delay. Staff #3 also confirmed that Resident #81's MDS assessment dated [DATE] was recorded in error and stated that she would correct it.

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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. Based on observations, record reviews, and interviews, it was determined that the facility failed to develop and implement comprehensive, resident-centered care plans. This was evident in 1 (Resident #42) of 3 residents reviewed for Activities of Daily Living (ADL).The findings include:A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the Resident's care. Staff use care plans to provide resident-centered care that includes support, services, and resources to meet Residents' needs.During a lunch observation on the memory care unit on 2/17/26 at 1:12 PM, Resident #42 was seated at the same table as two other residents. Resident #42 was observed taking food from the other residents' trays and eating it.A record review for Resident #42 included a psychiatry progress note dated 7/22/25, which stated that Resident #42 had a diagnosis of dementia with behavioral issues. The note also reported that staff observed Resident #42 yelling, being agitated, screaming at staff and other residents, and having difficulty with redirection. Staff requested a psychiatric evaluation.Continued record review included a social services progress note stating that Resident #42 was sometimes agitated, screamed at staff and other residents, and was difficult to redirect.During an interview on 2/19/26 at 11:15 AM, the unit manager (UM) for the memory care unit reported that Resident #42's usual behavior was to grab other residents' food.In an interview on 2/19/26 at 1:33 PM, staff #27, a geriatric nurse assistant (GNA), reported that Resident #42's usual behaviors included occasionally grabbing other residents' food, which upset some residents.However, an earlier record review failed to show that Resident #42's behaviors were addressed in his/her care plan, including the actions staff would take to address them.On 2/19/26 at 1:44 PM, the UM was notified that a comprehensive care plan addressing Resident #42's behaviors had not been developed or implemented, including staff interventions to address those behaviors. The UM reviewed Resident #42's care plans, confirmed the concern, and stated she would address it immediately.

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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. Based on record reviews and interviews, it was determined that the facility failed to conduct care plan meetings after the completion of the comprehensive assessments. This was evident for 2 (Resident #5, #41) of 2 residents reviewed for care planning. The findings include:1) Resident #5 had been residing in the facility since early 2024. The medical record indicated that the resident was cognitively intact. In an interview with the resident on 2/18/26 at 9:18 AM, s/he was asked about care plan meetings and stated, it's been a while, (social services director) Staff #20 had left and I don't know who took his place.A review of Resident #5's medical record was conducted on 2/18/26 at 2:30 PM. The review revealed the 2 most recent assessments were comprehensive assessments. A significant change assessment with an assessment reference date (ARD) of 1/8/26 and an annual assessment with an ARD of 10/30/25. A review of the resident's progress notes was also conducted and did not reveal any documentation regarding care plan meetings.The social services designee (Staff #19) was interviewed on 2/19/26 at 12:12 PM. During the interview, Staff #19 reported her process with care plan meetings and that she used to split the facility with Staff #20, based on room numbers. Care plan meetings were documented under the evaluation tab as IDT care plan conference summary. She confirmed that Staff #20 was no longer employed by the facility.A review of Resident #5's medical record was conducted with Staff #19 on 2/19/26 at 12:20 PM. Staff #19 reported that based on the resident's room number, s/he was assigned to Staff #20. She was also asked when the last care plan meeting was held for the resident and she reported 4/2/25. The concern was discussed with Staff #19 that the facility failed to hold a care plan meeting after the completion of the comprehensive assessments. She verbalized understanding and acknowledged the concern.2) Resident #41 Had been residing in the facility since 2024. The resident's medical record indicated that s/he was cognitively intact. During an interview with a resident on 2/18/26 at 8:49 AM, s/he stated, I can only remember the first meeting when asked if the facility conducts care plan meetings on a regular basis.A review of Resident #41's medical records was conducted on 2/18/26 at 2:50 PM. The review revealed the last 2 assessments conducted were an annual assessment with an ARD of 1/14/26 and a quarterly assessment with an ARD of 11/4/25. The resident's progress notes were also reviewed for care plan meetings and revealed a note from the social services designee (Staff #19) dated 1/27/26 that indicated a care plan meeting was scheduled for 1/29/26 at 2:30 PM. No other progress note was found to indicate that care plan meetings were held after the completion of the quarterly and the annual assessments.An interview regarding care plan meetings was conducted with Staff #19 on 2/19/26 at 12:12 PM. During the interview, Staff #19 explained her process and reported that care plan meetings are documented in the resident's evaluation as IDT care plan conference summary. A review of Resident #41's medical record was conducted with Staff #19 on 2/19/26 at 12:35 PM. She confirmed the progress note that she wrote indicating that a care plan meeting was scheduled for 1/29/26 however, the last documented IDT care plan conference summary was dated 11/7/25. Staff #19 reported that she did have the care plan meeting with the resident on 1/29/26 but failed to document it in the resident's medical record and stated, I'm responsible.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received showers. This was evident in one (Resident #110) of three Residents reviewed for ADL. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to collect information on each resident's strengths and needs. This information informs resident care planning decisions.During an interview on 2/18/26 at 8:54 AM, Resident #110 reported having received only one shower in the past 3 weeks. A review of Resident #110's admission MDS assessment dated [DATE] noted that the resident was totally dependent on staff for assistance with showers. A continued review of the shower schedule for the Unit where Resident #110 resided showed that s/he was to receive 2 showers per week, totaling 8 showers per month.Further review of the GNA (Geriatric Nurse Assistant) shower documentation for Resident #110 from 1/15/26 to 2/18/26 was completed. The review showed that Resident #110 received two showers in January and one in February. In an interview on 2/19/26 at 8:56 AM, staff #31, a geriatric nurse assistant, reported that Resident #110 was scheduled for 2 showers per week and a bed bath (washing a resident in bed using a basin of water, soap, and a washcloth without washing the hair) on non-shower days. However, an earlier review found that Resident #110 received only 3 showers between 1/15/26 and 2/18/26. During an interview on 2/19/26 at 1:57 PM with staff #11, a unit manager, she confirmed that Resident #110 received 3 showers between 1/15/26 and 2/18/26. Staff #11 added that she would ask her nursing assistants why Resident #110 was not offered showers on the days when s/he was scheduled to receive them. As of the survey exit on 2/23/26 at 4:15 PM, no additional documentation was provided showing that the resident received all scheduled showers during that period.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, it was determined that the facility failed to provide activities programs to meet residents' needs and preferences. This was evident for one (Resident#75) of one Resident reviewed for Activities.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information about each Resident's strengths and needs. The information collected informs Resident care planning decisions.During a tour of the memory care unit on 2/17/26 at 9:11 AM, Resident #75 was observed sitting alone at a table in the dining area, with his/her head bent over and no activity going on. In a later observation on 2/17/26 at 10:33 AM, Resident #75 remained seated in the same spot. A Chronicle paper was noted on the table in front of the Resident, and s/he was observed sleeping in his/her wheelchair. In a subsequent observation on 2/17/26 at 1:52 PM, Resident #75 had finished eating lunch, remained seated in his/her wheelchair in the dining area, was sleeping in the wheelchair, and there was no activity program.During an interview on 2/18/26 at 7:50 AM, Staff #27, a geriatric nursing assistant, reported that watching television [NAME] up Resident #75.A record review on 2/20/26 at 12:10 PM for Resident #75 showed a diagnosis of Dementia and altered mental status. The continued review included an MDS assessment dated [DATE], which noted that Resident #75 had severely impaired cognition.Further review included a care plan for Resident #75 stating that the Resident preferred to participate in time-limited activities of interest, such as table activities, old sitcoms, bingo, and music programs. Continued review of Resident #75's activity logs from January 1 to February 20, 2026, revealed the following: In December, socializing/social events and news & views occurred 34 times, music occurred 5 times, and bingo occurred 1 time. In January, socializing/social events and news & views were 25 times; music was 5 times.In February, socializing/social events, news & views, and music occurred 8 and 2 times, respectively.However, the logs did not indicate that Resident #75 was involved in activities related to television shows or sitcoms, as previously documented in his/her care plan as preferences.During an interview on 2/20/26 at 1:41 PM, staff #32, the activity director, reported that News & Views and socializing meant staff visited residents for a morning greeting, provided a daily chronicle, informed them of the day's activities, and encouraged them to attend. However, an earlier review of Resident #75's MDS assessment showed that s/he had severe cognitive impairment and relied on others for decision-making and self-care.During an interview on 2/23/26 at 9:23 AM, staff #33, an activity assistant, was present with staff #32. Staff #33 reported that Resident #75 liked watching TV. However, the TV had been moved to a different room and had not been working for several months. Staff #32 acknowledged the concern about not providing activity programs for Resident #75 based on his/her needs and preferences, and stated that they would do things differently moving forward.

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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. Based on observation, record review, and interview, it was determined that the facility failed to ensure appropriate pressure relieving device settings. This was evident for 3 (Resident #57,#93, and #118) of 3 residents observed with pressure injuries during the annual recertification survey. On 2/17/26 at 9:09 AM, the surveyor observed that Resident #93 had a pressure-relieving mattress on their bed. Resident#93 had a pressure injury and also had an order from the provider for the mattress with parameters for the settings to be within 10 pounds of the resident's current weight. The record revealed Resident #93's last documented weight on 02/03/2026 was 154 pounds. The pressure relieving mattress setting was inflated to 260 pounds. On 2/17/26 at 9:22 AM, the surveyor observed that Resident #57 had a pressure-relieving mattress on their bed. Resident #57 had a pressure injury and also had an order from the provider for the mattress with parameters for the settings to be within 10 pounds of the resident's current weight. The record revealed Resident #57's last documented weight on 02/03/2026 was 172 pounds. The pressure-relieving mattress setting was inflated to 220 pounds. On 2/17/26 at 9:35 AM, the surveyor observed that Resident #118 had a pressure-relieving mattress on their bed. Resident #118 had a pressure injury and also had an order from the provider for the mattress with parameters for the settings to be within 10 pounds of the resident's current weight. The record revealed Resident #118's last documented weight on 02/05/2026 was 163 pounds. The pressure relieving mattress setting was inflated to 220 pounds. On 2/19/26 at 11:53 AM, Staff #5 and Staff #17, both Geriatric Nursing Assistants (GNAs), completed a dual observation of the pressure relieving mattress for Resident #93 with the surveyor. Each was asked who was responsible for calibrating the mattress settings or checking the pressure settings, and Staff#5 and Staff #17 deferred to the licensed nursing staff being responsible for entering the resident's weight on the equipment. On 2/19/26 at 12:05 PM, Staff #18, a Licensed Practical Nurse (LPN) and the unit manager, was asked who sets up the pressure relieving mattress for a resident and how accurate weight settings are ensured. Staff #18 informed the surveyor that the facility's maintenance staff sets up the equipment in the room and deferred accuracy questions to the facility's wound nurse. On 2/19/26 at 12:13 PM, Staff #7, an LPN and the facility's wound care nurse, completed a dual observation of Resident #93,#57, #118's pressure relieving mattresses and was asked who ensured that resident weights are accurate, who trained staff on accuracy, and if audits were completed to ensure accuracy. Staff #7 explained that a resident's weight for the pressure relieving mattress is based on what is recorded in the resident's electronic medical record. Staff #7 explained that she can make adjustments as well as the unit manager, Staff #18. Staff #7 stated that when a provider enters an order, the facility used a durable medical equipment provider to deliver and service the equipment used by residents. Staff #7 explained that GNAs did not adjust or change the pressure relieving mattress settings, but are made aware of the appropriate setting. Staff #7 stated that they completed audits of pressure relieving mattresses throughout the facility, but they do not maintain documentation of those audits. During this observation and interview, Staff #7 confirmed that Resident #93, #57, and #118's pressure relieving mattress settings were not accurate. 2/19/26 at approximately at 1:30 PM, the findings were reviewed with the Nursing Home Administrator. He acknowledged the concern.

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NAME OF PROVIDER OR SUPPLIER Frederick Crossing of Journey		STREET ADDRESS, CITY, STATE, ZIP CODE 30 North Place Frederick, MD 21701	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure residents with oxygen therapy received oxygen as prescribed. This was evident for 1 (Resident #41) of 3 resident reviewed for respiratory care. The findings include:Resident #41 was admitted into the facility in early 2024 with diagnosis that includes acute respiratory failure with hypoxia.Hypoxia is a critical condition where tissues are deprived of adequate oxygen, causing symptoms like confusion, rapid heart rate, shortness of breath, and cyanosis (bluish skin). It is caused by lung issues, low blood oxygen (hypoxemia), anemia, or poor circulation. Treatment involves immediate oxygen therapy, medication, or ventilation.During an interview with Resident #41 on 2/18/26 at 8:55 AM, it was observed that the resident was receiving oxygen via nasal cannula set at 3.5 liters/min.A review of Resident #41's medical records on 2/20/26 at 9:33 AM revealed oxygen order to be administered at a rate of 2 L/min. There was no other documentation found to indicate that the rate of oxygen administration can be titrated or changed.On 2/20/26 at 3:08 PM, Resident #41 was observed sitting in bed, receiving oxygen via nasal cannula at a rate of 7 L/min.The registered nurse (RN #23) assigned to care for Resident #41 was invited for an interview in the resident's room on 2/20/26 at 3:10 PM. RN #23 confirmed that the resident was currently receiving oxygen at a rate of 7 L/min and when asked about the resident's usual use of oxygen, she stated, it fluctuates. Usually between 4 - 5 L/min but could be up to 6 L/min. RN #23 reported that there was an order to titrate the oxygen as needed because the resident suffers from panic attacks and when experiencing such episodes, her/his oxygen saturation (O2 sat) drops. RN #23 further reported that the resident experienced an episode at 1:30 PM and had an O2 sat of 88%.However, when Resident #41's medical record was reviewed with RN #23 on 2/20/26 at 3:15 PM, she confirmed that there was no order to titrate the rate of oxygen administration and there was no documentation to indicate that the resident's O2 saturation was 88% at 1:30 PM.The findings above were discussed with the nurse unit manager (Staff #18) on 2/20/26 at 3:29 PM. The concern was discussed that Resident #41 oxygen administration was being titrated without orders and current observation of the resident receiving oxygen at a different rate than prescribed. Staff #18 stated, I will address it right now and reported that she would discuss the concern with the Nurse Educator so that she may address it with RN #23.

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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. Based on record reviews and interviews, it was determined that the facility failed to ensure pain management was provided to residents according to professional standards of practice. This was evident for 2 (Resident #9, #41) of 4 residents reviewed for pain management. The findings include:1) Resident #9 had been residing in the facility since 2024. Diagnosis included but was not limited to chronic pain. A review of Resident #9's medical orders was conducted on 2/19/26 at 2:22 PM. The review revealed an order for narcotic pain medication to be taken on an as needed (PRN) basis and non-pharmacological interventions (NPI) to alleviate pain with numbers 1 through 8 that corresponded to the different interventions. Special instruction indicated to document all NPI's as needed.On 2/20/26 at 11:12 AM, a review of Resident #9's administration record for January 2026 revealed the PRN narcotic pain medication was administered 8 times. 3 of the 8 times the medication was administered failed to show documentation of the pain location, and there was no documentation to indicate NPI's were administered/attempted prior to giving the PRN pain medication.In an interview with the [NAME] President for clinical services (Staff #8) on 2/20/26 at 1:55 PM, the findings were reviewed. During the interview, Resident #9's medical record was reviewed with Staff #8 and she confirmed the finding. The concern was discussed that the nursing staff failed to document pain location and provide NPI's for pain management. Staff #8 verbalized understanding and acknowledged the concern.2) Resident #41 was admitted into the facility in early 2024. Diagnosis included but was not limited to osteoarthritis and spondylosis.A review of Resident #41's medical orders was conducted on 2/20/26 at 9:26 AM. The review revealed an order for pain medication to be taken on an as needed (PRN basis) and non-pharmacological interventions (NPI) to alleviate pain with numbers 1 through 8 that corresponded to the different interventions. Special instruction indicated to document all NPI's as needed.On 2/20/26 at 10:06 AM, a review of Resident #41's administration record for January 2026 revealed the PRN pain medication was administered 16 times. 2 of the 16 times the medication was administered for a 0/10 pain score, and there was no documentation to indicate NPI's were administered/attempted prior to giving the PRN pain medication.In an interview with the [NAME] President for clinical services (Staff #8) on 2/20/26 at 1:41 PM, the findings were reviewed. During the interview, Resident #41's medical record was reviewed with Staff #8 and she confirmed the finding. The concern was discussed that the nursing staff administered pain medication when there was no indication of pain for 2 instances and document NPI's provided prior to administering the PRN pain medication. Staff #8 verbalized understanding and acknowledged the concern.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, record reviews, and interviews, it was determined that the facility failed to implement appropriate interventions for a resident with an altered mental status and identified behaviors. This was evident in 1(Resident #42) of 2 residents reviewed for behaviors.The findings include:During a lunch observation on the memory care unit on 2/17/26 at 1:12 PM, Resident #42 was seated at the same table as two other residents, Resident #76 and Resident #72. Resident #42 was observed taking bread from Resident #72's lunch tray and eating it. After eating it, Resident #42 also took Resident #76's cake from Resident #76's tray. Resident #76 yelled and snatched the cake back from Resident #42's hand. After the surveyor's intervention, the staff moved Resident #42 to the TV room. Record review for Resident #42 included a psychiatry progress note dated 7/22/25, which stated that Resident #42 had a diagnosis of dementia with behavior.Continued record review included a social services progress note indicating that Resident #42 was sometimes agitated, screamed at staff and other residents, and was difficult to redirect.In an interview on 2/19/26 at 1:33 PM, staff #27, a geriatric nurse assistant (GNA), reported that Resident #42's usual behavior included occasionally grabbing other residents' food, which upset some residents.During an interview on 2/19/26 at 1:44 PM, the unit manager (UM) for the memory care unit reported that Resident #42's usual behavior was grabbing other residents' food. The UM reported that staff had tried a seating arrangement to prevent Resident #42 from taking other residents' food during mealtimes; however, it didn't work. The UM then added that staff would attempt the seating arrangement again at the meal tables to prevent Resident #42 from taking other residents' food. Later that same day, in an interview with the UM, she showed the surveyor a document outlining a new seating arrangement for residents, to be implemented after the surveyor's intervention to prevent Resident #42 from taking other residents' food during mealtimes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure safe and secure drug storage of resident medications. This was observed for 1 (North Hall) of 3 resident medication carts observed during the annual recertification survey. The findings include: On 2/19/26 at 7:25 AM, the medication administration observation was conducted on the 2 North unit with Staff #6, a Licensed Practical Nurse. When the surveyor approached the cart, Staff #6 was inside room [ROOM NUMBER] with the resident's room door shut. The resident medication cart was unlocked and unattended in front of room [ROOM NUMBER] and the surveyor was able to open and access the medication drawers. Staff #6 exited room [ROOM NUMBER] upon hearing the surveyor accessing the medication cart and acknowledged that it was unlocked and unattended. 2/19/26 at approximately at 1:30 PM, the findings were reviewed with the Nursing Home Administrator. He acknowledged the concern.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record reviews, and interviews, it was determined that the facility failed to conduct a comprehensive assessment of a resident's dietary dislikes and food preferences. This was evident in 1 (Resident #110) of 3 residents reviewed for food.The findings include:During an initial tour of the facility on 2/17/26 at 8:53 AM, Resident #110 was observed in bed eating breakfast. The Resident told the surveyor, Can you write on my ticket again that I don't like eggs? The Resident indicated that s/he had told the staff multiple times that s/he disliked eggs; however, s/he continued to receive eggs for breakfast. Resident #110's diet slip indicated a regular diet but did not list the Resident's preferences or dislikes.On another observation on 2/18/26 at 8:28 AM, Resident #110 was seated in a wheelchair at the bedside, eating breakfast. The Resident reported to the surveyor that s/he had again received scrambled eggs and added, I've told them several times that I don't like eggs, especially when they're not real eggs, and they keep bringing me eggs. I don't know why.A review of the record for Resident #110 showed that the Resident was readmitted to the facility in January 2026.Continued record review included a nutrition care plan initiated and revised on 1/20/26, which noted that the Resident had an alteration in nutrition r/t [related to] significant weight loss of 7.2% in 30 days with an associated decline in average intake. The care plan interventions included monitor intake, honor food preferences.Further review found a dietary profile for Resident #110, signed as completed on 1/27/26. The profile recorded the resident's diet order and the texture of food. However, the resident's food preferences and dislikes were left blank.During an interview on 2/18/26 at 2:51 PM, staff #29, a registered dietitian, stated that the dietary manager was primarily responsible for assessing residents' food preferences and dislikes and for entering that information into the meal ticket system. During an interview on 2/18/26 at 3:30 PM, staff #10, the dietary manager, reported that her process for assessing residents' food preferences and dislikes included meeting with residents, assessing and recording their food preferences and dislikes on the dietary profile, and then entering the data into their menu programming system. However, that process was missed for Resident #110.In a subsequent interview on 2/19/26 at 7:30 AM, staff #10 reported that she visited Resident #110 after the surveyor's intervention and assessed the Resident's food preferences, likes, and dislikes.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that an incompetent resident was documented as having consented to the arbitration process. This was evident for one resident (Resident #10) of 3 residents reviewed for arbitration agreements.The findings include:Resident #10 was admitted to the facility on [DATE]. A review of the resident's clinical record revealed that the resident lacked capacity to make decisions for themselves, which was documented by two providers on 11/16/25. Further review failed to reveal any evidence that the resident had a designated power of attorney (POA), guardian, or surrogate.On 2/19/26 at 9:30 AM the Nursing Home Administrator (NHA) was asked to provide a list of all residents who had arbitration agreements with the facility.On 2/19/26 at 11:07 AM a review of Resident #10's arbitration agreement was conducted and revealed that the document had an electronic signature that indicated the resident signed it on 12/03/25. On 2/19/26 at 11:08 AM an interview was conducted with the Director of Marketing and Admissions (Staff #9) to review the facility's process for arbitration agreements. When asked what she did if she wasn't sure whether a resident had capacity to sign legal documents, she explained that she checked the resident's records for any capacity/decision making forms and if the resident lacked capacity, then she would read through the document with the family. When asked about Resident #10's agreement and the process for how that agreement was obtained she said she was not sure if the resident or the family signed the agreement, but she might have written a note about it. She subsequently found her notes and provided a copy to the surveyor. A review of the note, which was dated 12/03/25, and written by Staff #9, revealed the statement Called [family member], discussed admission packet, signed [Resident #10] name to forms due to no POA assignment, also discussed with patient as much as possible so both were informed. Staff #9 confirmed her documentation.Resident #10's arbitration agreement was then reviewed with Staff #9, and she confirmed that she signed it on behalf of the resident.On 2/19/26 at 11:35 AM an interview was conducted with the NHA who acknowledged that Resident #10's arbitration agreement was completed incorrectly, and that Staff #9 should not have signed the resident's name on the document.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and interviews, it was determined that the facility failed to ensure all staff donned appropriate personal protective equipment (PPE) for enhanced barrier precautions. This was evident for 1 (Resident #111) of 5 residents reviewed for pressure ulcers. The findings include:Enhanced Barrier Precautions (EBP) - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).Resident #111 was admitted into the facility in late-2025. Medical records indicated that the resident was receiving hospice care.On 2/17/26 at 10:18 AM, the surveyor observed that Resident #111's door was closed. An EBP sign was posted with PPE supplies secured with a hanging storage on the door. After knocking and opening the door, a staff member was observed providing high-contact care for the resident. The staff was not wearing a gown but had a pair of gloves on. The surveyor informed staff that s/he would come back when she was done providing the resident's care. While waiting outside Resident #111's room, another staff member went into the resident's room. On 2/17/26 at 10:34 AM, the new staff member that arrived, stepped out and reported that she was a hospice nurse and that the staff inside was the hospice aide (Staff #22) who had just finished giving the resident a bed bath. After confirming that Resident #111 was dressed, Staff #22 was interviewed in the resident's room. She confirmed that she was a hospice aide that comes into the facility 2x a week to provide personal care that includes bathing, feeding and personal hygiene. Staff #22 was asked about PPE and stated, I've never worn a gown with him/her, just gloves. I didn't know I had to. At this time, Staff #22 noticed and pointed out the EBP sign on the resident's door that indicated gown and gloves must be worn for high contact resident care activities (including dressing, bathing, changing linens). Staff #22 also confirmed that the resident had wounds.The observation of Staff #22 not wearing appropriate PPE while providing high contact care to Resident #111, was discussed with the facility's infection preventionist nurse (Staff #13) on 2/19/26 at 10:13 AM. Staff #13 stated, she (referring to Staff #22) definitely should have and reported that all staff, including hospice staff, were aware of the resident's special precaution. Other than the EBP sign on the resident's door, the information would also be part of the usual reporting between the staff. Staff #13 also reported that Resident #111 was placed on EBP since 10/20/25 due to wounds.