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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interviews, it was determined that the facility failed to assess a resident for behavioral health needs following a change in behavior. This was evident for 1 (Resident #121) of 4 residents reviewed for accidents during the survey.The findings included: On 1/29/26 at 2:15 PM, review of intake #2714236 revealed that Resident #121 was transported to the hospital for a behavioral emergency on 1/11/26.On 1/29/26 at 2:20 PM, review of progress notes added as a late entry on 1/12/26 and dated 1/9/2026 revealed that Social Services visited Resident #121 based on concerns expressed by a staff member to check on the resident's welfare. Further review of the Social Services note revealed that the resident was calm, pleasant, and redirectable. Continued review failed to reveal that a suicide ideation assessment interview was completed with Resident #121.On 1/29/26 at 2:25 PM, continued review of a progress note dated 1/11/2026 revealed that Resident #121 was found lying on the floor with a plastic bag over their head. Continued review revealed that the resident was assessed and transported to the hospital. The police, physician and family were notified.On 1/29/2026 at 3:39 PM, Social Worker (Staff #23) was interviewed. During the interview, the social worker reported visiting Resident #121 on 1/9/26, due to staff concerns regarding the resident's behavior. The social worker further reported that a suicide ideation assessment was not completed because the social worker was not aware that the resident had voiced a desire to die previously to a Nursing Aide. The social worker reported reviewing the resident's medical record and did not find documentation indicating that the resident voiced a desire to die. Social Worker Staff #23 reported that a brief suicide ideation assessment would have been conducted if the social worker had been aware that the resident voiced a desire to die.On 1/29/2026 at 3:00 PM, review of progress notes revealed a nurse's note which referred to the date 1/8/2026. Further review revealed that the note was added as a late entry on 1/13/2026 and was not available to the social worker on 1/9/2026, prior to the Social Workers interview/visit with Resident #121. Review of the late-entry note revealed that the nurse was notified by a nursing assistant reporting that Resident #121 did tell the nursing assistant that the resident wanted to die.On 1/29/26 at 3:55 PM, the Social Services Director provided the facility's Social Services policies and procedures regarding suicide precaution management. Review of the policy revealed that the facility was required to complete a brief suicide ideation assessment for current residents who voiced or indicated suicidal ideation in any manner.On 1/30/26 at 9:59 AM, the Clinical Services Director (CSD, Staff #20) was interviewed. During the interview, the concern was discussed that the social worker did not have all pertinent information regarding Resident #121 prior to interviewing the resident on 1/9/26. The CSD confirmed that the pertinent information was not documented or available to the social worker at the time of the interview and that a brief suicide ideation assessment was not completed.

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