STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50573 Based on record review and staff interviews, it was determined that the facility failed to notify the primary care provider when there was a resident change of condition or a potential need to alter treatment. This was evident for 1 (Resident #28) of 6 residents reviewed for unnecessary medication. The findings include: Review of Resident #28's medical record on 8/29/24 revealed that the resident had a diagnosis of hypothyroidism and has had an order for levothyroxine once a day since 7/10/24. On 8/29/24 at 11:15 AM, review of Resident #28's medication administration revealed that the resident refused levothyroxine on 15 days between 7/12/24 and 8/3/24. Levothyroxine is a thyroid medication that is used to treat an underactive thyroid gland. The thyroid gland makes thyroid hormones which help to control energy levels and growth. When the medication is not taken, the thyroid level can be out of normal range. On 08/29/24 at 11:57 AM, review of Resident #28's medical record failed to reveal that the primary care provider was notified of the repeated medication refusal. On 8/29/24, review of Resident #28's medical record revealed on 8/6/24, the facility acknowledged a result from routine blood work that indicated an elevated thyroid level. The routine blood work order was placed on 7/10/24, the same day that the levothyroxine was ordered for the resident. On 08/29/24 at 01:28 PM, an interview with the Director of Nursing (DON) revealed that, when a resident frequently refuses medication, the expectation is that the primary care provider is contacted. On 08/29/24 at 01:42 PM, the surveyor reviewed concerns with the Director of Nursing (DON) regarding the failure to ensure THAT a provider was notified when a resident frequently refuses medication.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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** 50573 Based on observation and interview, it was determined that the facility failed to ensure the conditions of the facility were safe, clean, and without unaddressed concerns. This was found to be evident for 1 ([NAME] Creek 2 unit) out of 4 units observed throughout the survey. The findings include: 1) On 08/15/24 at 10:27 AM, an initial observation on the [NAME] creek 2 unit revealed an area about 10 inch wide where wallpaper was torn, and some pieces of drywall were noted to be crumbled right above the floor, behind the entry door of room [ROOM NUMBER]. On 08/15/24 at 12:26 PM, further observation on the [NAME] Creek 2 unit revealed about 5 inches of wallpaper peeled off about one third of the way to the ceiling outside of the dining room doorway, about a 6 foot tea-like stain on the floor in front of the water fountain, a section of the bottom corner of the nurses station which looked to be damaged, and a rolling chair at the nurses station where several pieces of the outside material had been stripped. On 08/22/24 at 01:30 PM, an observation on the [NAME] Creek 2 unit revealed wallpaper next to the hallway door border of room [ROOM NUMBER] that was peeling about 3 inches and across the hall a missing section of wallpaper and exposed drywall was noted on the hallway door border of room [ROOM NUMBER]. On 08/22/24 at 01:45 PM, an observation on the [NAME] Creek 2 unit revealed about 2- 3 inches of an exposed corner wall metal brace and a corner adjacent with a second exposed corner wall metal brace was exposed about 3-4 inches. The dark tea-like stain in front of the water fountain noted on a previous observation was still present. The section of the bottom of the nurses station, which looked to be damaged, was observed again and was in the same condition as the initial observation. On 08/26/24 at 09:08 AM, an observation on the [NAME] Creek 2 unit revealed that the dark tea-like stain in front of the water fountain noted on the previous two observations was still present. The two corners with exposed corner wall metal braces previously observed were in the same condition. On 08/26/24 at 01:49 PM, an observation on the [NAME] Creek 2 unit revealed the wallpaper concerns on the outside door borders of room [ROOM NUMBER] and 249 were in the same condition as when they were first observed. On 08/27/24 at 02:44 PM, an interview with the maintenance director (Staff #46) revealed that he was not aware of any maintenance concerns or active maintenance work orders for the [NAME] Creek 2 unit. Further interview revealed that the facility had an electronic platform where staff can report maintenance concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 02:55 PM, the surveyor walked with Staff #46 on the [NAME] Creek 2 unit and showed him the concerns noted throughout the survey. He indicated that he was not aware of the wall tear behind room [ROOM NUMBER]'s entry door when the surveyor pointed it out and he made a note on a notebook he had in his hand. The surveyor showed Staff #46 the two corner wall metal braces that were exposed, and he also noted the concern on the notebook. When the surveyor pointed out the concern on the bottom corner area of the nurses station that was exposed he indicated that it was not repairable and they are working on replacing it and that the whole side of it had been affected. The surveyor showed Staff #46 the wallpaper concerns that were observed throughout the survey and he said that they have pickers on the unit and maintenance tries to glue down the areas of peeled wallpaper. The surveyor showed Staff #46 the rolling chair at the nurses station that was ripped in several areas and he noted the finding. When the surveyor pointed out the tea-like colored stain in front of the water fountain, he said that he was aware of it and that the stain was waxed over and plans to address it when they strip and rewax the floor. 2) On 08/26/24 at 09:15 AM, an observation of room [ROOM NUMBER]'s bathroom on the [NAME] Creek 2 unit revealed a brown colored smudge about 2 inches long on the bathroom railing and a pink dried substance on the adjacent railing about an inch long. On 08/26/24 at 01:48 PM, an observation of room [ROOM NUMBER]'s bathroom on the [NAME] Creek 2 unit revealed the brown and pink marks present on room [ROOM NUMBER]'s bathroom railing. On 08/26/24 at 01:52 PM, an interview with house keeping (Staff #43) on the [NAME] Creek 2 unit revealed that she had not yet cleaned the rooms on the hallway that included room [ROOM NUMBER]. On 08/27/24 at 10:30 AM, the brown and pink marks on room [ROOM NUMBER]'s bathroom railing noted twice previously were still in the same condition. On 08/27/24 at 10:36 AM, the surveyor observed housekeeping (Staff #45) on the [NAME] Creek 2 unit cleaning a room and the surveyor asked to show Staff #45 an observation. Staff #45 walked with the surveyor to room [ROOM NUMBER]'s bathroom to show the observation on the bathroom railing noted from the previous day. The surveyor indicated that it was observed the day previously and Staff #45 responded that she would take care of it. On 08/27/24 at 03:36 PM, the surveyor reviewed the concern regarding the bathroom railing in room [ROOM NUMBER]'s bathroom with the housekeeping manager (Staff #47) and district housekeeping manager (Staff #48) and they indicated that they were told about the concern and had addressed it. On 08/29/24 at 01:42 PM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to ensure that the conditions of the facility were safe, clean, and free from unaddressed concerns.

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F 0600 Level of Harm - Minimal harm or potential for 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. 40927 Based on records review and interviews, it was determined that the facility failed to protect residents from abuse. This was evident in 4 (Resident #9, #28, #104, and #424) of 21 residents reviewed for abuse. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) On 8/22/24 at 8:53 AM, a review of the facility's investigation file for the facility reported incident #MD00182597 revealed a self-report form that documented a staff member had witnessed Resident #424 being abused on 4/20/22 at 2:30 PM by another staff member. Review of Physical Therapist (PT) #52's handwritten statement, dated 4/20/22, revealed that she had answered Resident #424's call light and the resident asked to go to bed. PT #52 reported that she asked the resident's assigned geriatric nursing assistant (GNA) #53 to assist her with the transfer. She stated that the resident was a sit to stand transfer with minimum assist, however, when the resident was in the standing position GNA #53 pushed the resident from the right side causing the PT to lose control of the resident and the resident fell halfway onto the bed. She reported that as she assisted the resident fully onto the bed, GNA #53 was mocking the resident as the resident was asking the GNA to leave the room. Review of Resident #424's statement, that was taken by the ADON, revealed the resident confirmed the incident that was reported by PT #52. The resident reported that s/he had asked GNA #53 about 50 minutes earlier to put him/her to bed and s/he had to wait. It was the second time the resident had put on their call light for assistance that PT #52 had answered the call light and asked GNA #53 to assist. The resident reported that GNA #53 had hurt his/her right arm and was bad. The facility called the police, notified the ombudsman, and reported GNA #53 to their licensing agency. Further review of the investigation file revealed that facility staff failed to have evidence of interviews and/or assessments of other residents who had been in the care of GNA #53 to ensure no one else had been abused. The facility failed to interview other staff who may have had knowledge of the incident, or the care provided to other residents by GNA #53. It was evident that the facility failed to conduct a thorough investigation of the incident. A medical record review for Resident #424 on 8/21/24 at 3:13 PM revealed a minimum data set (MDS), with an assessment reference date of 4/14/22. Review of the document revealed that the resident had no cognitivei mpairment (the ability to think and process information) or behaviors, and relied on the staff to provide activities of daily living (getting in and out of bed, personal care, toileting, and etc.). On 8/28/24 at 9:54 AM, the concerns were reviewed with the Director of Nursing and the Assistant Director of Nursing. Neither of them were in their current positions at the time of the incident. The Administrator, at the time of the incident, was no longer there. The DON was unable to find the original investigation file and had printed what they could find in the computer to recreate the file. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross Reference F610 2) A medical record review for Resident #170 on 8/27/24 at 11:11 AM revealed the resident had resided in the facility since 2021. Review of an attending physician's visit note, dated 1/16/24, revealed the resident suffered from chronic hip pain, knee pain, and major depressive disorder. Review of the MDS, with the assessment reference date of 1/18/24, revealed in section C that the resident had no cognitive impairment and in section GG the resident utilized a walker to ambulate. A medical record review for Resident #104 on 8/27/24 at 12:47 PM revealed a discharge summary from the hospital in 12/2023 that documented the resident had dementia. The MDS, with an assessment reference date of 12/20/23, revealed the resident had moderate cognitive impairment. Section GG showed the resident also used a walker and required minimal assistance to get in and out of bed. A review of the facility's investigation file for the self-reported incident #MD00202094 on 8/27/24 at 12:06 PM revealed a final self-report form that documented Resident #104's roommate was standing at the sink and heard some strange noises. When the roommate turned to see what was going on, s/he witnessed Resident #170 inappropriately touching Resident #104 while s/he laid in bed. The roommate stated that Resident #104 looked uncomfortable. The roommate told Resident #170 to leave the room and then went to report what s/he saw to the staff at the nurses' station. In the summary section, it was noted that Resident #104 was observed shaking and holding their head. Resident #104 told staff s/he wanted to call their spouse to take them home. Review of the statement from Resident #170 revealed the resident admitted to touching the resident inappropriately, but stated it was an accident. The facility failed to have evidence that they interviewed other residents who may have been abused by this resident. Further review revealed that local law enforcement were called and removed Resident #170 from the facility under an emergency protection order and the resident was subsequently charged with assault 2nd degree and sex offense 4th degree. The resident was not permitted to return to the facility. An interview with the Director of Nursing on 8/27/24 at 1:54 PM, revealed that they had interviewed 2 residents who had been alert and oriented on that hallway and found the resident had not abused them. She reported that, after the incident, she talked with Resident #170's family who reported the resident had been at a hospital for mental illness, however the facility was unable to obtain records from the hospital. The DON reported they were monitoring Resident #104 for ill effects from the abuse and had offered victim support information, but the resident and family declined. This was confirmed with documentation in the medical record. 50573 3) Review of Resident #28's medical record revealed that Resident #28 is dependent on staff for Activities of Daily Living (ADLs) and had a diagnosis of dementia. On 08/21/24 at 10:57 AM, review of the Facility Reported Incident Initial Report From, submitted to the State Survey Agency, for MD00206318, revealed that Resident #24, who was the only witness, reported that Geriatric Nursing Assistant (GNA, Staff #34) hit Resident #28 while she was feeding him/her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the final report for MD00206318 on 8/21/24 revealed the facility did not substantiate the abuse because of insufficient information and that Resident #24 who reported the allegation had a Brief Interview for Mental Status (BIMS) of 7 and when the facility later interviewed her/him, they were unable to recall the incident. A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS score ranges from 0 to 15, with 0 indicating severe cognitive impairment and 15 indicating intact cognition. Review of the investigative documentation provided by the facility related to this report revealed a hand written and signed statement by Staff #34, which stated, While I was feeding Resident #28's room number at the dinning room, she started spitting [his/her] food on me. I tapped on [his/her] left shoulder to stop it. Further review of the final report failed to reveal indication that a written statement was made by the alleged staff member indicating that she did tap Resident #28 on the shoulder. On 08/22/24 at 10:44 AM, a phone interview with GNA #34 revealed that Resident #28 was spitting her/his food out and the GNA told the resident to stop and the resident did not, so she tapped the resident on the shoulder to stop. On 08/22/24 at 2:10 PM, review of a typed interview with GNA #34 dated 6/4/24 that was signed by the Director of Nursing (DON) and provided to the surveyor after the phone interview with GNA #34, stated .GNA #34 said Resident #28 was eating very slowly and she was trying to get Resident #28 to eat. [S/he] kept spitting out [his/her] food and she kept telling [him/her] not to spit out the food. She stated that she tapped [him/her] on the left shoulder as she was sitting in front to get [his/her] attention to eat. She tapped [him/her] with her fingers on the left shoulder and stated it was just a tap that she didn't hit her. Review of the facility's agency Do Not Return list revealed Staff #34's name. On 8/26/24 at 3:51 PM, the surveyor reviewed with the DON the concern that based on review of the documentation and surveyor interview with the GNA #34, abuse was substantiated. 48470 4) Resident #9 had been residing in the facility since 2017. The resident submitted a complaint related to MD00208809 that indicated 2 nurses refused to administer his/her medications on 8/11/24 and 8/14/24. On 8/23/24 at 2 PM, Resident #9's care plan was reviewed and revealed problems that include refusal of care. The interventions for this problem included to monitor and document the behavior and to reattempt to give care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 2:16 PM, Resident #9's administration history, that included but was not limited to behavior monitoring, medication administration, and treatment administration for August 11 and 14 of 2024 was reviewed. The review suggested that the nurse on duty on 8/11 for the 7-3 shift was licensed practical nurse (LPN Staff #57), and the nurse on duty on 8/14 for the 7-3 shift was LPN Staff #56. The review revealed: a) on 8/11/24, the area where the nurse on duty was supposed to document the behavior for refusal of care was blank; 14 routine medications were blank, 8 of which were once a day medication; and all 7 scheduled treatments were blank. b) On 8/14/24, Staff #56 documented 0 episodes of refusal of care; 4 routine medications were not administered and the nurse on duty documented under comment, resident ignored writer when attempted to administer. 1 of the 4 medications was scheduled to be administered once a day between 7 AM to 3 PM, and another was scheduled to be administered once a day at 12:30 PM only on Mondays, Wednesdays, and Fridays; all treatments were administered as scheduled. A subsequent review of Resident #9's electronic health record revealed a progress note from Staff #56 on 8/14/24 created at 4:51 PM, that stated When writer attempted to administer resident's 1300 medications, resident was at the time sitting in her room, eating lunch. Upon knocking and entering room, writer addressed resident by her name and resident did not respond but continued to eat lunch. Resident an hour later came to the nurses offices as writer was on break, demanding medications and eye drops. Management already made aware of refusal and refusal documented. Further review of the progress notes revealed no evidence of documentation from the nurse on duty on 8/11/24. On 8/23/24 at 2:53 PM, the Director of Nursing (DON) was interviewed about medication administration and her expectation from staff when a resident refuses or declines a medication. The DON reported that she expects staff to document the refusal by documenting in the electronic Medication Administration Record (eMAR) and progress notes, and to notify the provider and responsible party. On 8/26/24 at 9:41 AM, a review of the daily staff post documentation confirmed that Staff #57 and Staff #56 were the nurses on duty at the time of the allegation event. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue with a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident, but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24 while Staff #56 was still on duty. However, there was no evidence of the investigation conducted by the DON and the ADON. The findings in Resident #9's administration history was discussed with both staff where Staff #57 failed to administer 14 medications along with treatments, and no documentation of refusal of care; and Staff #56 failed to administer or reattempt to give the resident's medications when s/he was asking for them as evidenced by her progress note. Subsequently on the same day at approximately 4 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11 AM, the concern was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) regarding the deprivation of goods and services to a resident on 2 occasions. Staff #2 indicated that Staff #56's action did not make sense since the resident was already asking for his/her medications and questioned why didn't she just give them after her break? No explanation was offered by the DON or the ADON.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48470 Based on records review and interviews, it was determined that the facility failed to implement their abuse policies and procedures by 1) failing to report all allegations of abuse to the state agency and the facility's abuse coordinator and 2) failing to conduct a thorough investigation of all allegations of abuse. This was evident for 1 of 1 policies and procedures reviewed for abuse, neglect, exploitation, or mistreatment and has the potential to affect all residents of the facility. The findings include: A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The policies and procedure indicated in the bottom of the document that it had a complete revision on 11/1/2017. In the section under Policy, item number 2. indicated that if the events that cause the allegation involve abuse, the facility shall report immediately, but no later than 2 hours after the allegation is made to the administrator of the facility and to other officials (including state survey agency) in accordance with the state law. Item number 3. stated, The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment and will implement immediate action to safeguard resident. And item number 5. stated The facility's Leadership will designate a staff member to oversee the abuse prohibition policy (Facility Abuse Coordinator) During the survey process, the surveyor had identified 3 occurrences through interviews and records review where residents had reported allegations of abuse to staff, but the facility's leadership failed to report the incident to the state agency and failed to conduct a thorough investigation of the allegation. The 3 occurrences were: 1) On 8/15/24 at 3:50 PM, while in an interview with Resident #19, s/he reported a Geriatric Nursing Assistant (GNA) who allegedly called him/her numerous names. The allegation was reported to the Director of Nursing (DON) and the GNA was taken off the floor and was not allowed to care for Resident #19 anymore. The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and indicated that when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report. 2) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff #30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents. A subsequent interview with the DON on 8/21/24 at 12:49 PM, the concern was discussed that the resident's allegation was not reported to the state agency. The DON indicated that the resident was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. The DON acknowledged the concern and reported that she would report all allegations from now on. 3) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. Subsequently on the same day at approximately 4 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. In an interview with the Nursing Home Administrator (NHA) on 8/27/24 at 9:55 AM, he reported that he was the facility's abuse coordinator. The DON sends reports on behalf of the facility. The NHA reported the facility's process when an abuse allegation is made and indicated that all allegations are reported to him prior to investigations and him reporting the event to regional staff. In a subsequent interview with the NHA on the same day at 3:07 PM, the 3 allegations identified above was discussed. The NHA reported that he does not recall the incident with Resident #19, he was not aware initially about Resident #9's allegation against the GNA who was assigned to him/her on 8/17/24 and confirmed that refusing to administer medications was a type of abuse and a reportable offense. The NHA acknowledged the concern that the DON had not reported and thoroughly investigated all the allegations being brought to her attention. On 8/29/24 at 11 PM, the concern was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) that the facility failed to implement its policies and procedures for the prevention of abuse as evidenced by allegations made by residents were not reported to the facility's abuse coordinator, not reported to the state agency, and no thorough investigations were conducted on several occasions. All 3 staff acknowledged the concern. Cross reference F609, F610

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37276 Based on records review and interviews, it was determined that the facility failed to 1) have an effective system in place to ensure that all allegations of abuse are reported to the state agency, 2) to ensure that reports are sent within the mandated timeframe, and 3) to report the results of the investigation no later than 5 working days after the incident. This was evident in 6 (Resident #19, #9, #6, #25, #67, and #92) of 21 residents reviewed for abuse. The findings include: 1) On 8/26/24 at 2:50 PM, a review of facility reported incident MD00200510 revealed that, on the morning of 12/12/23, Resident #25 reported to a staff member that a GNA (geriatric nursing assistant) had made a movement like s/he was going to hit the resident. On the self-report form, the facility documented the date of the incident was 12/11 to 12/12/23 and reported by the resident on 12/12/23. The facility's initial self-report indicated the allegation of abuse was reported to the state agency on 12/12/23 at 12:40 PM and the final report was reported to the state agency on 12/19/23 at 1:50 PM. During an interview on 8/28/24 at 3:54 PM, the Director of Nursing (DON) stated she thiought that she was made aware of the allegation of abuse the morning of 12/12/23, around 9:00 AM, that she could not recall the exact time, but it was before the morning meeting. The time the facility reported the allegation to the state office was past the 2-hour required timeframe. In addition, the facility failed to report the results of the investigation no later than 5 working days after the incident. The concerns with the late reporting of an allegation of abuse were discussed with the DON at that time, and the DON verbalized understanding. 48168 2). On 8/26/24 at 9:00 AM, a review of complaint #MD00208610 revealed an allegation that staff yelled at and hit Resident #67. On 8/26/24 at 12:10 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. When asked if there were any FRIs for Resident #67, the ADON said she did not have any. On 8/26/24 at 4:21 PM in an interview with Unit Manager (Staff #5), she said she was aware of an allegation of abuse for Resident #67. She thought it happened on a weekend. Staff #5 further explained that she informed the Director of Nursing (DON) of the allegation and thought the DON did an investigation. When asked what the process was for reporting alleged abuse, Staff #5 said that the DON was immediately notified, anytime 24/7, even if it was the weekend, and that the ADON and DON alternated taking call on the weekends. When asked if she remembered the date of the alleged incident, she said she could not remember. When asked if she has record of it, she said she did not. She further explained that sometimes she helped investigate allegations, but she did not investigate this incident. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 1:44 PM an interview with the DON was conducted. The DON stated she learned of the allegation of abuse for Resident #67 from the unit manager, who had a phone message left on her unit manager phone on a weekend. The DON said she asked the resident, who said the incident did not happen, and since the resident denied the occurrence, the facility did not do an investigation or make a report. The DON confirmed that this did not meet the regulatory requirements to report and investigate all allegations of abuse. 3). On 8/28/24 at 1:16 PM, a review of the FRI #MD00191798 revealed an allegation that Resident #92 was abused by another resident (Resident #77) on 4/18/23. A review of the facility's investigation file revealed an Initial Self-Report report to the Office of Health Care Quality (OHCQ) dated 4/26/23 at 5:30 PM with a corresponding email confirmation. The facility's investigation file also contained a typed witness statement, dated 4/18/23, by Licensed Practical Nurse (LPN #37) who witnessed the incident. On 8/28/24 at 2:54 PM an interview with the DON was conducted to review the FRI #MD00191798 report, the facility's investigation file, and the timing of the facility's self-report. The DON confirmed that, since the incident occurred on 4/18/23 but was not reported to OHCQ until 4/26/23, the facility was not compliant with reporting regulations. 48470 4) Resident #19 had been residing in the facility since 2015. In an interview with the resident on 8/15/24 at 3:50 PM, the resident reported that a Geriatric Nursing Assistant (GNA) who still worked for the facility was calling him/her numerous names, including being referred to as the devil. The resident indicated that this happened about 5-6 months ago, and that it had been reported to the Director of Nursing (DON). The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and indicated that, when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report. On 8/27/24 at 8:09 AM, the Corporate Clinical Nurse (Staff #2) reported to the surveyor that she would be interviewing the resident, and that the facility had started a formal investigation of the allegation. 5a) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff #30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed. On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a subsequent interview with the DON on 8/21/24 at 12:49 PM, the concern was discussed that the resident's allegation was not reported to the state agency. The DON indicated that the resident was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. The DON acknowledged the concern and reported that she would report all allegations from now on. 5b) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident, but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. Subsequently on the same day at approximately 4:00 PM, the DON reported that she would start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. 6) Resident #6 was admitted into the facility in late 2023. A facility reported incident (FRI) investigation packet related to MD00207289, regarding abuse, was reviewed on 8/23/24 at 10:52 AM. The review revealed that the allegation was reported to the wound nurse (Staff #58) by the resident on 7/1/24 at approximately 9:00 AM. Further review of the investigation packet revealed the FRI initial report form that stated the form was submitted on 7/2/24 at 7:00 PM. The confirmation email that the initial report was submitted was dated 7/2/24 at 7:37 PM. The DON was interviewed on 8/23/24 at 12:09 PM and the concern was discussed that the initial report for an allegation of abuse was sent approximately 34 hours after the facility was made aware. The DON acknowledged the concern and offered no explanation. A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The review revealed a section titled Reporting/Response and item number 1 stated, All alleged violations concerning abuse, neglect, or misappropriation of property are reported immediately to Abuse coordinator, NHA, other officials in accordance with the state law including state survey and certification agency. On 8/29/24 at 11:00 AM, the findings were reviewed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) and the concern was discussed that allegations of abuse must be reported to the state agency and that reports must be submitted within the mandated timeframe. All staff verbalized understanding and acknowledged the concern.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. 48168 Based on record review and staff interview, it was determined that facility staff failed to conduct a thorough investigation of abuse and maintain evidence of the investigation. This was evident for 7 (#424 #19, #9, #41, #92 #322, #67) of 21 residents reviewed for abuse and for 3 facility reported incidents reviewed for abuse (FRIs) (#MD00194834, and #MD00207292, and #MD00191798), of 34 FRIs investigated during the recertification survey. The findings include: 1). On 8/27/24 at 12:03 PM a review of the Office of Health Care Quality (OHCQ) report #MD00194834 revealed an allegation that staff mistreated Resident #322 on 7/27/23 when they ripped the remote control from the resident's hand. On 8/27/24 at 12:10 PM, the facility's investigation file was obtained and reviewed. Although the file contained a suspension notice for a Geriatric Nursing Assistant (GNA #38), the file lacked 1) any staff witness statements, 2) evidence that Resident #322 had a physical assessment done after the incident, and 3) assignment sheets of staff on duty at the time of the incident. 4) demographic and clinical information regarding the resident and the resident's care needs at the time, 5) any evidence of education provided to staff after the alleged incident. The file also contained a skin assessment for Resident #322, dated 7/29/24. On 8/27/24 at 1:31 PM, an interview with the Director of Nursing (DON) was conducted to review the facility's investigation file. The DON confirmed that there were no staff statements, no resident information or assessment, no evidence of education or follow up other than the suspension notice, and that the clinical documentation, dated 7/29/24, could not have been part of the investigation because it occurred more than one year later. On 8/27/24 at 3:19 PM, an interview with the Nursing Home Administrator (NHA) was conducted and he was informed of the incomplete investigation. He said he had only worked at the facility for 10 months, and that he understood the investigation was not thorough. 2). On 8/26/24 at 3:18 PM, a review of the FRI #MD00207292 revealed an allegation that, on 6/30/24, a male Geriatric Nursing Assistant (GNA #11) grabbed Resident #41's leg and left a mark on it. On 8/26/24 at 3:20 PM, a review of the facility's investigation file revealed that, although the alleged perpetrator wrote a statement on his suspension notice, there were no other staff statements in the file. A typed statement by the Assistant Director of Nursing (ADON) indicated that she conducted resident and staff interviews, but did not indicate who was interviewed, nor was there a list of staff on duty at the time. And although the ADON wrote a statement that she spoke with the Resident #41, who indicated being safe, there was no statement from Resident #41 about the actual incident. The file also lacked the 5-day final report to OHCQ and lacked any evidence of education provided to staff about abuse prevention and reporting. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 1:20 PM, the DON was interviewed about the facility's investigation of the alleged abuse of Resident #41. When asked about the lack of pertinent information in the investigation file, the DON stated she might have some additional information in her computer, but she did not have time to make sure it was complete before giving it to the survey team, and she also confirmed that the investigation should have included names of staff and residents who were interviewed. The DON confirmed that the investigation file was incomplete. On 8/27/24 at 3:19 PM, an interview with the NHA was conducted regarding the incomplete investigation and he validated that this was a deficiency. 3). On 8/28/24 at 1:16 pm a review of the FRI #MD00191798 revealed that Resident #92 made an allegation of abuse against Resident #77 on 4/18/23. On 8/28/24 at 2:00 PM a review of the facility's investigation file revealed a staff witness statement by Licensed Practical Nurse (LPN #37) which described an incident that occurred on 4/18/23 around 7 PM. The typed statement was dated 4/18/23 and contained an illegible signature, and indicated it was an interview of LPN #37. The file lacked 1) any clinical or identifying information for either resident involved, 2) no other staff or resident witness statements, 3) no roster of residents on the unit, and 4) no list of staff on duty at the time. The file also contained the 5-day Final Report which included a statement that Resident #92 wanted to press charges against Resident #77, but there was no police report case number or officer name listed in the file. On 8/28/24 at 2:54 PM an interview with the DON was conducted regarding the facility's investigation of the allegation that Resident #92 was abused by Resident #77. When asked, the DON said the typed interview statement of LPN #37 was written by the facility Social Worker (SW #39) who no longer worked at the facility, although her name was not legible on the document. The DON also confirmed that the facility's investigation file lacked other staff or resident witness statements, lacked a roster of resident census or staff duty assignment, lacked documentation of follow up of resident's aggressive behavior, lacked evidence of education provided to the staff after incident, and lacked evidence of a police report filed per Resident #92's request. The DON validated that the investigation was incomplete. 48470 4) Resident #19 had been residing in the facility since 2015. In an interview with the resident on 8/15/24 at 3:50 PM, the resident reported that a Geriatric Nursing Assistant (GNA) who still works for the facility was calling him/her numerous names including being referred to as the devil. The resident indicated that this happened about 5-6 months ago and that it had been reported to the Director of Nursing (DON). The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and indicated that when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report. On 8/26/24 at 1:29 PM, a review of Resident #19's medical records failed to reveal evidence that the allegation was investigated and unsubstantiated. No record was found to indicate that the resident and/or other residents were interviewed, and staff were interviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The review revealed a section titled Guidelines for Investigation and stated in item G Interview individuals having first-hand knowledge of the incident and write summaries of the interviews. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated facility staff and interviewer will record all witness accounts in a document, written, dated and signed by the interviewer. On 8/27/24 at 8:09 AM, the Corporate Clinical Nurse (Staff #2) reported to the surveyor that she would be interviewing the resident, and that the facility had started a formal investigation of the allegation. On 8/29/24 at 11:00 AM, the concern was discussed with the DON, Assistant DON, and the Corporate Clinical Nurse (Staff #2) that an allegation of abuse was not thoroughly investigated. All staff acknowledged the concern. 5) Resident #9 had been residing in the facility since 2017. The resident's medical records indicated that s/he was cognitively intact with a BIMS of 15. BIMS : stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. During the survey process, the surveyor had identified allegation of abuse that involved Resident #9. These allegations were: a) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff # 30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed. On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents. In a subsequent interview with the DON on 8/21/24 at 12:49 PM, she reported that she reviewed the GNA's schedule to see which residents were assigned to the staff. None of the other residents had any complaints or concern with the staff and that Resident #9 was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. b) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the ADON on 8/26/24 at 11:01 AM, both staff confirmed that Resident # 9 had brought to their attention about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Subsequently on the same day at approximately 4:00 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. On 8/29/24 at 11:00 AM, the allegations made by Resident #9 was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) and the concern was discussed that there was no evidence that the allegations were investigated. All staff verbalized understanding and acknowledged the concern. 40927 6) On 8/22/24 at 8:53 AM, a review of the facility's investigation file for the facility reported incident #MD00182597 revealed a self-report form that documented a staff member had witnessed Resident #424 being abused on 4/20/22 at 2:30 PM by another staff member. Further review of the investigation file revealed that facility staff failed to maintain evidence that they had interviewed and/or assessed other residents who had been in the care of GNA #53 to ensure no one else had been abused. They facility failed to interview other staff who may have had knowledge of the incident, or the care provided to other residents by GNA #53. The facility also failed to maintain a completed investigation and evidence as to when it was sent to the state agency. On 8/28/24 at 9:54 AM, the concerns were reviewed with the Director of Nursing and the Assistant Director of Nursing. Neither of them were in their current positions at the time of the incident. The Administrator, at the time of the incident, was no longer there. The DON was unable to find the original investigation file and had printed what they could find in the computer to recreate the file. Cross Reference F600

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#95) of 3 residents reviewed for pressure ulcers, 1 (#112) of 4 residents reviewed for accidents and and 3 (#1, #33, #6) of 3 residents reviewed for Resident Assessment. 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. MDS assessments must be accurate to ensure that each Resident receives the care they need. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods. 1a) On 8/15/24 at 5:15 PM, Resident #95 was observed to be receiving oxygen via a nasal cannula (device that delivers extra oxygen through a tube and into your nose), which was connected to an oxygen concentrator. On 8/20/24 at 3:30 PM, a review of Resident #95's electronic medical record (EMR) revealed, that following an acute hospitalization , the resident was readmitted to the facility in April 2024 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #95's August 2024 Respiratory Administration History record revealed a 4/23/24 order for oxygen at 2 Liters per minute via nasal canula every shift that was signed off as administered every shift from 8/1/24 to 8/19/24, and 8/20/24 dayshift. Review of Resident #95's quarterly MDS, with an Assessment Reference Date (ARD) of 8/12/24, revealed Section 0, Special Treatments, Procedures, Respiratory Treatments, C1. Oxygen therapy, b. While a Resident, was blank, and not coded to indicate Resident #95 had received oxygen therapy during the MDS's 7-day look-back period, which was inaccurate. 1b) On 8/21/24 at 10:11 AM, continued review of Resident #95's EMR, revealed documentation that the resident was receiving Hospice Care while a resident in the facility. A Hospice Plan of Care documented Resident #95 began hospice services, in mid-June 2024, and had a terminal diagnose of COPD and heart failure. On 6/21/24 at 2:01 PM, in a social service note, the Social Worker (SW) wrote that the Resident #95 was currently under hospice care. Review of Resident #95's quarterly MDS assessment with an ARD of 8/12/24, revealed Section 0, Special Treatments, Procedures, K1. Hospice care, while a resident, was blank, and not coded to indicate Resident #95 received hospice services during the MDS's 7-day look back period, which was inaccurate. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) Further review of Resident #95's EMR revealed documentation indicating Resident #95 had a right shoulder pressure ulcer, and a sacrum pressure ulcer, received daily treatments to the pressure ulcers and was seen by the wound care practitioner weekly. Review of Resident #95's August 2024 treatment administration record (TAR) revealed an 8/2/24 physician's order for daily wound treatment to the right hip which was signed off as completed every day from 8/2/24 to 8/8/24, then discontinued on 8/9/24 and a wound treatment order to the right hip initiated on 8/9/24, that was signed off as completed every day from 8/9/24 to 8/19/24. In addition, Resident #95's August 2024 TAR also documented a 6/27/24 order for daily wound treatment to the sacrum, which was signed off as being completed every day from 8/2/24 to 8/10/24. Review of Resident #95 wound practitioner notes revealed, on 8/9/24, in a Wound Evaluation and Management Summary, the wound practitioner documented had a Stage 3 pressure wound of the right hip, and a Stage 4 pressure wound of the Sacrum. Review of Resident #95's quarterly MDS with an ARD of 8/12/24, Section M, Skin Conditions, M0300 Current Number of Unhealed Pressure Ulcers/Injuries at each Stage revealed MDS inaccuracies. Section M, Skin Conditions, M0300 Current Number of Unhealed Pressure Ulcers/Injuries at each Stage documented Resident #95's number of Stage 3 pressure ulcers was 1, that the resident's number of Stage 4 pressure ulcers was 0, and his/her number of unstageable pressure ulcer due to coverage of the wound bed by slough and or eschar was 1. The MDS inaccurately documented Resident #95 had an unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar and failed to accurately document that Resident #95 had one Stage 4 pressure ulcer. On 8/22/24 at 2:42 PM, the concerns with the MDS failing to accurately code Resident #95's pressure ulcers were discussed with Staff #6, MDS Coordinator, and Staff #6 confirmed the inaccuracies at that time. The Director of Nurses (DON) was made aware of the above MDS concerns on 8/23/24 at 9:55 AM, and the DON offered no further comments at that time. 2) On 8/16/24 at 11:33 AM, a medical record review of Resident #1 revealed a quarterly MDS assessment dated [DATE], Section N. Medications, documented Resident #1 received an anticoagulant during the MDS look back period. On 8/23/24 at 10:32 AM, a review of Resident #1's June 2024 and July 2024 Medication Administration Record (MAR), failed to reveal an evidence that an anticoagulant had been prescribed for Resident #1 or that an anticoagulant had been administered to the resident during the MDS look back period. 3) On 8/16/24 at 1:28 PM, a medical record review of Resident #33 revealed an annual MDS assessment dated [DATE], Section N. Medications that documented Resident #33 received an anticoagulant during the MDS look back period. On 8/23/24 at 11:01, review of Resident #33's June 2024 MAR failed to reveal an evidence that an anticoagulant had been prescribed for Resident #33 or that an anticoagulant had been administered to the resident during the MDS look back period. 4) On 8/16/24 at approximately 12:30 PM, a medical record review of Resident #6 revealed an MDS assessment dated [DATE], Section N. Medications, that documented Resident #6 received an anticoagulant during the MDS look back period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/23/24 at 11:26 AM, a review of Resident #6's May 2024 MAR failed to reveal an evidence that an anticoagulant had been prescribed for Resident #6 or that an anticoagulant had been administered to the resident during the MDS look back period. On 8/23/24 at 12:10 PM, the DON was made aware of the above concerns and the surveyor requested to speak to the MDS coordinator. The concerns with the coding of the MDS for the above residents was discussed with Staff #6, MDS coordinator on 8/23/24 at 1:45 PM. Staff #6 confirmed the inaccuracies at that time, and no other comments were offered. 50573 5) On 08/16/24 at 10:57 AM, record review revealed that Resident #112 had a fall on 6/5/24 and was sent to the hospital Further record review on 08/16/24 revealed Resident #112 was admitted to the hospital for a fracture on part of the right thigh bone and needed surgery as a result. On 8/19/24 at 12:47 PM, review of the MDS with an Assessment Reference Date (ARD) of 6/5/24 failed to reveal the fall coded. Further record review on 8/19/24 revealed the MDS with an ARD of 6/20/24 which failed to reveal the fall nor the fall with major injury coded. On 08/22/24 at 02:11 PM, an interview with MDS coordinator (Staff #36) revealed that she uses progress notes to code the MDS for residents. When the surveyor asked about coding falls, she indicated that if a resident has a fall and gets admitted to the hospital they complete a discharge MDS and code the fall. If the resident gets readmitted to the facility the reentry MDS should be coded accordingly, if they had a significant injury with the fall (like a fracture) it would be coded and if they had surgery from the fall it would also be coded. On 08/22/24 at 02:12 PM, the surveyor reviewed the 6/5/24 and 6/20/24 MDS concern with Staff #36 regarding the coding not accurately reflecting the resident status and she agreed it was inaccurate coding. On 08/29/24 at 01:42 PM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to ensure that the MDS reflects a resident's status.

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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. 37276 Based on observation, medical record review and resident and staff interview, it was determined the facility failed to implement interventions based on a resident's comprehensive care plan. This was evident for 1 (#25) of 3 residents reviewed for communication/sensory and 1 (#108) of 4 residents reviewed for accidents. 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 8/16/24 at 11:16 AM, during an interview, Resident #25 appeared hard of hearing and had difficulty hearing the surveyor. When asked if the resident attended activity programs, Resident #25 stated s/he did not attend activity programs because s/he could not hear. Resident #25 also reported that the resident could not hear at all in one of his/her ears, and s/he was hard of hearing in the other ear. Resident #25 also reported s/he had hearing aids that had not been worn since forever. On 8/21/24 at 11:25 AM, a review of Resident #25's medical record revealed a communication care plan, [Resident #25] may have difficulty understanding others R/T (related to) hearing loss with chronic wax build-up, that had the goal, will hear and comprehend communication, demonstrated by being able to follow simple 1 step directions through the review date, with approaches that included, Hearing aides are kept in the med cart. They are to be put in with AM care and removed at HS (hours of sleep). Review of Resident #25's July 2024 Medication Administration Record (MAR) revealed a 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM [9:00 AM], and off in the PM [9:00 PM], and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 8 (7/7, 7/19, 7/24, 7/26, 7/27, 7/28, 7/30, 7/31) out of 31 days in July 2024, and that a hearing was placed only in the left ear on 4 (7/3, 7/9, 7/4, 7/16) days in July 2024. Review of Resident #25's August 2024 MAR revealed the same 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM, and off in the PM and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented that hearing aids were not placed in Resident #25's ears on 13 (8/1, 8/2, 8/3, 8/4, 8/6, 8/7, 8/8, 8/9, 8/10, 8/12, 8/13, 8/15, 8/25) of 26 days in August 2024, and that a hearing was placed only in the left ear on 3 (8/14, 8//18, 8/26) days in August 2024. The facility failed to follow the care plan by failing to implement the approach, for the hearing aids to be put in with AM care and removed at HS. The concerns with failing to implement the care plan were discussed with the Director of Nursing (DON) on 8/28/24 at approximately 3:20 PM. The DON acknowledged the concerns at that time, and no further comments were offered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48470 2) A review of Resident #108's medical records indicated that s/he was admitted to the facility in June of 2024. The Resident was transferred from the hospital after a fall that s/he suffered from home. On 8/22/24 at 9:45 AM, a subsequent review of Resident #108's medical record revealed that s/he had fallen 12 times since being admitted to the facility. Furthermore, a facility reported incident (FRI) related to MD00207141 was sent to the Office of Healthcare Quality that investigated the falls that had occurred. At the conclusion of the FRI, it indicated that the corrective actions the facility had implemented included a review of all interventions to verify that they are appropriate. This was submitted by the Director of Nursing (DON) on 7/5/24 at 6:30 PM. In reviewing Resident #108's care plan on 8/22/24 at 11:46 AM, it revealed that the resident was identified as a fall risk. The care plan had interventions to prevent and protect the resident from falls that include the utilization of a fall mat to be placed on the right side of the bed. Resident #108's room was observed on 8/15/24 at 12:40 PM, 8/21/24 at 11:03 AM, and 8/22/24 at 12:28 PM. 3 of the 3 observations failed to show evidence that a fall mat was put in place as stated in the resident's care plan. On 8/22/24 at 12:41 PM, Resident #108's orders, including discontinued and completed orders, were reviewed and failed to reveal evidence that an order to utilize a fall mat was instituted. In an interview with the DON on 8/22/24 at 2:12 PM, she was asked if Resident #108 used a fall mat and if a doctor's order was needed for this intervention. The DON replied yes to both questions and indicated that the fall mat was on the right side of the bed. The DON was reviewing the resident's medical record and was asked if she was able to find the order for the fall mat. The DON reported that she could not find the order and indicated that staff might have forgotten to put the order back when the resident was hospitalized . Following the review of the order history of Resident #108 by the DON, she confirmed that the fall mat was never ordered. The surveyor also discussed with the DON that there was no observation of the fall mat in the resident's room, and that she had documented in the FRI follow up report that all interventions were evaluated to be appropriate, but failed to implement them. On 8/29/24 at 11 AM, the concern was discussed with the DON, Assistant DON, and the corporate clinical nurse that the facility failed to implement a care plan regarding the fall mat use to protect the resident from falls. All staff verbalized understanding and acknowledged the concern.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37276 Based on observation, medical record review and staff interview, it was determined the facility failed conduct care plan meetings and review and revise resident care plans after each assessment. This was evident for 1 (#25) of 3 residents reviewed for communication/sensory, 1 (#95) of 2 residents reviewed for respiratory and 1 (Resident #6) of 2 residents reviewed for care planning. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status 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 residents care. 1) On 8/15/24 at 5:15 PM, Resident #95 was observed to be receiving oxygen via a nasal cannula (device that delivers extra oxygen through a tube and into your nose), which was connected to an oxygen concentrator. At that time, Resident #95 was also observed to have a Foley catheter (indwelling urinary catheter that drains urine from the bladder into a collection bag outside the body). On 8/20/24 at 3:30 PM, a review of Resident #95's electronic medical record (EMR) was conducted, and revealed, that following an acute hospitalization , Resident #95 was readmitted to the facility in April 2024 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), and obstructive and reflux uropathy (urinary tract condition that occurs when urine can't drain properly, and urine flows backward into the kidneys). Review of Resident #95's most recent MDS assessments revealed a completed quarterly assessment with an assessment reference date (ARD) of 7/7/24 and a quarterly assessment with an ARD of 8/12/24. 1a) Review of Resident #95's August 2024 Respiratory Administration History record revealed a 4/23/24 order for oxygen at 2 Liters per minute via nasal canula every shift that was signed off as administered every shift from 8/1/24 to 8/19/24, and 8/20/24 dayshift. Review of Resident #95's care plans revealed a care plan, [Resident #25] requires oxygen therapy and medication, with the goal, [Resident #5] will not exhibit signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse) through the review date. Review of the Resident #95's care plan evaluations, revealed that the resident's care plan had been reviewed on 6/29/24. No further documentation was found to indicate the resident's oxygen therapy care plan had been evaluated for effectiveness and revised as needed following his/her assessments on 7/7/24 and 8/12/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b) Further review of Resident #95's medical record revealed, on 4/19/24, in a History and Physical note, the physician documented Resident #95's diagnoses included BPH (benign prostatic hyperplasia) with urinary retention, continue Foley. Review of Resident #95's August 2024 Treatment Administration Record (TAR) revealed a 4/19/24 order for an indwelling Foley Catheter for neurogenic bladder (bladder dysfunction caused by nervous system conditions) that was signed off as in place every shift from 8/1 to 8/19/24. A 7/31/24 order to change Foley once a week on Tuesday for Urinary tract infection, that was documented as completed on 8/6/24 and 8/13/24. Review of Resident #95's care plans revealed an Indwelling Catheter care plan, [Resident #95] has a foley catheter, requires enhanced barrier precautions, and at risk for infection (UTIs - hx (history) of chronic): diagnosis of obstructive uropathy and BPH, with the goal, [Resident #95] will be free from catheter related infection. Review of the Resident #95's care plan evaluations, revealed that the resident's Foley catheter care plan was last evaluated on 6/29/24. No further documentation was found to indicate that the resident's care plan had been evaluated for effectiveness and revised as needed following his/her quarterly assessments on 7/7/24 and 8/12/24. On 8/23/24 at 9:55 AM, the Director of Nurses (DON) made aware of the concerns with the failure to evaluate care plans following each assessment and the DON acknowledged the concerns at that time. 2) On 8/16/24 at 11:16 AM, during an interview, Resident #25 appeared hard of hearing and had difficulty hearing the surveyor. When asked if the resident attended activity programs, Resident #25 stated s/he did not attend activity programs because s/he could not hear. Resident #25 also reported that the resident could not hear at all in one of his/her ears, and s/he was hard of hearing in the other ear. Resident #25 also reported s/he had hearing aids that had not been worn since forever. On 8/21/24 at 11:25 AM, a review of Resident #25's medical record revealed documentation that the resident resided in the facility for long term care since late 2018. Review of Resident #25's July 2024 Medication Administration Record (MAR) revealed a 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM [9:00 AM], and off in the PM [9:00 PM], and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 8 (7/7, 7/19, 7/24, 7/26, 7/27, 7/28, 7/30, 7/31) out of 31 days in July 2024, and that a hearing was placed only in the left ear on 4 (7/3, 7/9, 7/4, 7/16) days in July 2024. Review of Resident #25's August 2024 MAR revealed the same 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM, and off in the PM and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 13 (8/1, 8/2, 8/3, 8/4, 8/6, 8/7, 8/8, 8/9, 8/10, 8/12, 8/13, 8/15, 8/25) of 26 days in August 2024, and that a hearing was placed only in the left ear on 3 (8/14, 8/18, 8/26) days in August 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's most recent quarterly MDS with an assessment reference date (ARD) of 8/6/24, revealed Section B - Hearing, Speech and Vision, documented the resident used a hearing aid. Review of Resident #25's care plans revealed a communication care plan, [Resident #25] may have difficulty understanding others R/T (related to) hearing loss with chronic wax build-up, that had the goal, will hear and comprehend communication, demonstrated by being able to follow simple 1 step directions through the review date, with approaches that included, Hearing aides are kept in the med cart. They are to be put in with AM care and removed at HS (hours of sleep). Review of the care plan evaluations for Resident #25's communication care plan revealed on 8/28/24, the nurse documented, Care plans, approaches and interventions reviewed and remain appropriate. Continue with current POC (plan of care). There was no indication Resident #25 daily use of hearing aids in both ears had been evaluated, or that the resident's lack of use of a right ear hearing aid had been identified, and interventions revised based on the resident's needs. On 8/28/24 at 3:54 PM, the concerns with failing to evaluate the care plan following each assessment was discussed with the Director of Nurses (DON, and the DON acknowledged the concerns with evaluating and revising care plan goals and interventions following each assessment based on the resident's needs. 48470 3) Resident #6 was admitted to the facility in late 2023. In an interview with the resident on 8/16/24 at 12:34 PM, the resident was asked about his/her or a family members participation with care plan meetings. The resident reported that s/he did not, nor did s/he think his/her family was invited to a care plan meeting. On 8/20/24 at 1 PM, Resident #6's medical records were reviewed and revealed a care conference note with a reference date of 1/31/24 documented by the social services department assistant (Staff #28). No other care conference note was found in the resident's medical record. A subsequent review of Resident #6's medical records revealed that after the care conference on 1/31/24, the resident has had quarterly MDS assessments completed with Assessment Reference Dates (ARD) of 3/19/24, 5/7/24, and 8/7/24. On 8/21/24 at 2:08 PM, Staff #28 was interviewed about her process with care plan meetings or care conferences. Staff #28 reported that whenever she attended a care plan meeting, she wrote all the details down in a care conference paper note then later types all the information in the resident's Electronic Health Record (EHR) under the label Care Conference Note. She also reported that she kept all the hard copies even after typing all the information in the EHR. The concern was discussed with Staff #28 that the only evidence of a care plan meeting held for Resident #6 was the care conference note that she documented on 1/31/24. Staff #28 explained that when Resident #6 was newly admitted , the resident was hard to talk to and that might be the reason why she did not document in the EHR and stated, that would be a mistake on my end. Staff #28 then indicated that she would look at her hard copies of the care conference paper notes. The surveyor requested for all the notes she could find for the resident for this year (2024) (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 3:04 PM, Staff #28 reported that the only hard copy she found for Resident #6 was for the care conference note she documented on 1/31/24. Staff #28 confirmed that no other care plan meeting was held for Resident #6. On 8/29/24 at 11:00 AM, the concern was discussed with the Director of Nursing, Assistant Director of Nursing, and the Corporate clinical nurse that the resident has only had 1 care plan meeting to date and that they are not being done within the mandated timeframe after the completion of the MDS assessments. All staff acknowledged the concern.

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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. 16218 Based on record review, observation and interview, it was determined that the facility failed to ensure activities were provided to residents based on their preferences and as indicated in their care plan. This was found to be evident for 2 (Resident #113 and #28) out of 5 residents reviewed for activities. The findings include: 1) Review of Resident #113's medical record revealed a Minimum Data Set (MDS) assessment, with an assessment date of 6/7/24, that revealed the resident was interviewed in regard to Activity Preferences and that the resident had indicated it was very important to listen to music that s/he likes and to be around animals such as pets. Review of the care plan for activities, created on 6/6/24, revealed several approaches including: Provide activity calendar and review some of the programs and available materials and equipment available for use; Staff will meet with resident to see if enjoyment is gained from activities or self-directed routine; Staff will assist resident in participating in favorite activities such as watching tv; Staff will encourage resident to participate in animal visitation programs when available; Staff will invite, make arrangements, offer materials, or assistance to facilitate participation in music interests such as listening to music in room and invite to live music entertainment when available; and Staff will offer one to one visits to prevent social isolation. On 8/21/24 review of the activity documentation sheets for June and July 2024 failed to reveal sheets for Resident #113. At 3:40 PM, surveyor informed the Activity Director (Staff #35) that no documentation was found for the resident for June or July, and requested documentation for August. At 4:12 PM, the Activity Director reported she could not find activity documentation for Resident #113. As of time of survey exit on 8/29/24 at 3:30 PM, no documentation was provided to indicate that activity staff had conducted any of the approaches in Resident #113's activity care plan. 50573 2) On 08/15/24 at 01:15 PM, an interview with the Resident #28's responsible representative revealed that he was concerned about the lack of activities. On 08/19/24 at 01:40 PM, review of Resident #28's care plan revealed a focus that the resident was dependent on meeting social and emotional needs. Some approaches listed were: staff would provide the resident's favorite activities such as Spanish music, magazines, religious services, and outdoor activities. On 08/21/24 at 11:44 AM, an interview with the Activities Director (Staff #35) revealed that residents are provided activities based on their interests evaluated by the comprehensive assessment and embedded into their care plan. Further interview revealed that each resident had an activity log to keep track of what activities that the facility was providing and when the residents' attended. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive assessment in a nursing home is a detailed evaluation of a patient's health, needs, and condition, and is used to identify the services they need. It's a tool that nurses use to create a plan of care for a patient. On 08/22/24 at 09:19 AM, review of Resident #28's comprehensive assessment section F: preferences for customary routine activities, with an assessment reference date (ARD) of 5/2/24, revealed that it was very important for the resident to have items to read such as magazines, to get fresh air, and to participate in religious services. On 08/22/24 at 10:34 AM, review of Resident #28's activity log provided for June 2024 failed to reveal consistent activities such as Spanish music or magazines that are based on his/her care plan and assessment. The activity log for July failed to reveal activities such as Spanish music or magazines that are based on his/her care plan and assessment. The activity log for August failed to reveal activities such as Spanish music, magazines, outside, or religious activities that are based on his/her care plan and assessment. On 08/27/24 at 09:20 AM, the surveyor reviewed the concern with Staff #35 that activities provided to the resident were inconsistent with the care plan and assessment. Staff #35 indicated that it had slipped through the cracks and that she had been the only activities personnel at the facility since July 2024. On 08/29/24 at 01:42 PM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to ensure that residents are provided activities of interest based on the comprehensive assessment and care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40927 Based on record review and interview, it was determined that the facility failed to 1) have a process in place to monitor resident's air pressure mattress settings and ensure that they were appropriate for the resident's current weight which resulted in a harm to Resident #3 and 2) ensure that a resident's change in condition was evaluated by a primary care provider. This was evident for 1 (#3) of 8 residents reviewed for falls and 1 (#110) of 2 residents reviewed for skin conditions. The findings include: Low air loss mattresses are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown. Air continually flows through tiny laser-made air holes in the top of the mattress surface so that the user floats on a soft cushion of air. (https://homecarehospitalbeds.com). A control box is placed on the footboard that controls the air flow into the mattress. 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) A medical record review for Resident #31 on 8/28/24 at 11:35 AM revealed a history and physical examination conducted by the attending physician on 2/1/23 that documented the resident had been admitted from home because of care needs. According to the weights, the resident weighed 214.8 lbs. (pounds) at the time of admission. However, the resident experienced weight loss and was down to 178.8 lbs. , by 5/2023 and was ordered a low air loss mattress because the resident had some pressure areas and was refusing to get out of bed. The air flow settings for the mattress were based on the resident's weight. Further review revealed that the resident experienced a significant weight loss of 35.7 lbs. over an 11-month period. Further review of the medical record revealed there was an order for the low air loss mattress, but no documentation of the air flow settings or orders to monitor the settings. Review of the resident's care plan for pressure ulcers revealed an intervention for an APM [air pressure mattress] however, the settings were not included in the intervention. Also, there was no intervention to monitor the settings to ensure they were correct. On 8/27/24 at 9:55 AM, a review of the facility's investigation file for the facility reported incident #MD00205907 revealed a statement from Geriatric Nursing Assistant (GNA) #50 taken by Licensed Practical Nurse (LPN) #30 that she heard the resident scream and went to the room to find the resident lying on the floor. According to the statement, the resident was lying on their back with their legs bent sideways with obvious trauma to the one leg. The resident was placed back into bed with a mechanical lift. A review of the final investigation report revealed the resident was dependent on staff to roll them back and forth, making it unlikely that the resident rolled out of the bed. The facility had determined that the low air loss mattress was set on a 5, and with the resident's current weight it should have been on a 3. This caused over inflation of the air mattress which caused the resident to slide out of bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed diagnostic imaging reports for x-rays taken of the pelvis and the right lower leg. The resident suffered a hip fracture and a fracture of the proximal tibia and fibula (two bones in the lower leg). Review of the orthopedic consultation on 4/26/24, revealed that it was recommended to have surgical intervention for the broken hip, however, there were greater risks associated with the surgery due to the resident's medical condition. Review of a progress note, dated 4/29/24, revealed that the resident and family opted to have the surgery. An interview with the DON on 8/28/24 at 9:30 AM confirmed that the fall had been due to the low air loss mattress being over inflated and the resident fell out of bed. The DON further reported that once a week, they meet to discuss residents with weight loss, pressure sores, and falls. However, they had not been reviewing the low air loss mattress settings when the resident had weight loss. In addition, she confirmed that there were no orders for monitoring the air flow settings on the control box to ensure they were correct and ensure the safety of the resident. Furthermore, she reported that when a resident had the machine with the knob control, the controls could be moved accidentally, but the ones with a button control would not be easily moved. She stated that, when a resident was placed on the low air loss mattress, they would obtain a weight and give that information to the maintenance director who would set the air flow based on the manufacturer's guidelines, and he would put the setting on a sticker and place it on the control box. Once it was set, there was no process in place to check the settings to ensure they had not been moved or when a resident lost weight to check the manufacturer's guidelines to change the settings as needed. After the incident occurred, the residents with weight loss and a low air loss mattress were checked to ensure that the settings were appropriate for their current weight. During an interview with the Maintenance Director on 8/29/24 at 11:44 AM, he reported that, as he was conducting audits to make sure that the low air loss mattress settings matched the setting that he wrote on the sticker on the control box, he found the settings were being changed. He reported that sometimes, the residents will lean on the low air loss mattress control box that hangs on the end of the bed and it will change the level accidentally. A subsequent interview with the DON on 8/29/24 at 12:04 PM revealed she was aware that the Maintenance Director was finding settings that had been changed accidentally during his audits. With these findings, facility staff failed to put an intervention into place to monitor the settings to ensure that they remained on the correct air flow level to prevent this incident in the future. 50573 On 08/15/24 at 03:29 PM, an interview with Resident #110's responsible representative revealed that the nursing staff had informed her of a mass on the resident's groin earlier in the week and had indicated that the Nurse Practitioner (NP) would be seeing the resident but when she came to the facility today staff had no knowledge of the resident being seen by the NP. The responsible representative also reported she has addressed this issue with the Director of Nursing (DON). On 08/19/24 at 09:00 AM, record review revealed that on 08/09/2024 at 12:35 AM, a progress note was completed by Licensed Practical Nurse (LPN, Staff #9) which indicated the resident was swollen in the upper thigh/groin area and that report would be given to the day nurse to follow up with the Nurse Practitioner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 12:55 PM, review of the door access log revealed that Nurse Practitioner (Staff #41) was in the facility on 8/12/24. Further review of the medical record failed to reveal documentation to indicate the swelling to the groin was reported to the nurse practitioner or other primary care provider until a SOAP note was completed by the Director of Nursing (DON) on 8/15/24 which indicated the primary care provider was notified. A SOAP note is a written document that healthcare workers use to record information about patient encounters in a structured way. Record review on 8/29/24 at 10:10 AM revealed a progress note completed by Registered Nurse (Staff #42) on 8/15/24 which indicated an antibiotic was ordered for the abscess. Further record review, revealed a progress note by Licensed Practical Nurse (Staff #32), dated 08/16/2024 at 10:52, which indicated that Nurse Practitioner (Staff #41) looked at the resident's abscess and wrote a new order for a different antibiotic to treat the cellulitis diagnosis. Cellulitis is a bacterial infection that affects the skin's deeper layers and underlying tissue. Further review of the medical record failed to reveal documentation written by the NP about the area on the resident's groin until 8/21/24. On 08/26/24 at 10:10 AM, record review revealed a note by Nurse Practitioner (Staff #41) dated 8/21/24, for the mass on Resident #110's groin area. This is more than a week after nursing first identified swelling in the resident's groin area on 8/9/24. On 08/26/24 at 03:51 PM, the surveyor reviewed the concern that there was a progress note on 8/9/24 indicating swelling in the groin area and the facility did not notify the provider until 8/15/24. The DON responded oh yeah I did the SOAP note but that was 8/15/24. On 8/26/24 at 3:51 PM, the surveyor reviewed with the Director of Nursing (DON) regarding the failure to ensure that a resident's change in condition was reported and evaluated by a primary care provider.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 37276 Based on observation, medical record review and resident and staff interview, it was determined the facility failed to ensure that residents receive proper treatment and assistive devices to maintain hearing abilities. This was evident for 1 (#25) of 3 residents reviewed for communication/sensory. The findings include: On 8/16/24 at 11:16 AM, during an interview, Resident #25 appeared hard of hearing and had difficulty hearing the surveyor. When asked if the resident attended activity programs, Resident #25 stated s/he did not attend activity programs and indicated it was because s/he could not hear. Resident #25 also reported that s/he could not hear at all in one of his/her ears, and hard of hearing in the other ear. When asked if the resident had hearing aids, Resident #25 responded that s/he had hearing aids, but reported that the hearing aids had not been worn since forever. On 8/21/24 at 11:25 AM, a review of Resident #25's medical record was conducted. Review of Resident #25's July 2024 Medication Administration Record (MAR) revealed a 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM [9:00 AM], and off in the PM [9:00 PM], and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 8 (7/7, 7/19, 7/24, 7/26, 7/27, 7/28, 7/30, 7/31) out of 31 days in July 2024, and that a hearing was placed only in the left ear on 4 (7/3, 7/9, 7/4, 7/16) days in July 2024. Review of Resident #25's August 2024 MAR revealed the same 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM, and off in the PM and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 13 (8/1, 8/2, 8/3, 8/4, 8/6, 8/7, 8/8, 8/9, 8/10, 8/12, 8/13, 8/15, 8/25) of 26 days in August 2024, and that a hearing was placed only in the left ear on 3 (8/14, 8/18, 8/26) days in August 2024. Continued review of Resident #25's medical record revealed on 6/22/24 at 12:28 PM, in a progress note, the nurse wrote that s/he could not find Resident #25's right ear hearing aid. The nurse wrote that s/he and the GNA (geriatric nursing assistant) searched for it on the resident's but and could not find it. Report passed on to evening shift nurse to keep searching. In a progress note on 7/6/24 at 10:00 PM, the nurse documented Resident #25's left hearing aid was off and on the medication cart and the resident's right hearing aid could not be found, and the resident had stated it was missing. No other documentation was found in the medical record to indicate a search for Resident #25's hearing aid had been conducted, or whether the hearing aid had been found. On 8/27/24 at approximate 2:45 PM, prior to entering Resident #25's room for an observation, when asked about the resident's status, Staff #29, Registered Nurse (RN) indicated Resident #25 was hard of hearing and recommended the surveyor speak into the resident's left ear. Staff #29 stated that Resident #25 was wearing a hearing aid in the left ear, and indicated the resident did not have a hearing aid for his/her right ear. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at approximately 3:20 PM, during an interview, when asked if Resident #25 wore hearing aids, Staff #30, Licensed Practical Nurse (LPN), Unit Manager (UM), stated that Resident #25 had bilateral hearing aids, which were kept on the medication cart. At that time, Staff #30 was made aware Resident #25's July and August MAR documented hearing aids were not placed in both of the resident's ears every day as ordered, and the documentation also indicated Resident #25's right hearing aid was missing. Staff #30 responded that the resident misplaced his/her hearing aids before and when Resident #25 lost a hearing aid, the nursing staff would search for the hearing aid, ask laundry & kitchen to search, and then notify the resident's representative and social services. When made aware that the documentation in the progress notes on 6/22/24 an on 7/6/24 indicated Resident #25's right ear hearing aid was missing with no further documentation found to indicate a search for the hearing aid had been conducted, Staff #30 stated that a grievance (expression of dissatisfaction) about the missing hearing aid would be submitted. On 8/28/24 at 3:54 PM, the Director of Nursing (DON) was made aware of the above concerns related to the facility staff failing to ensure that hearing aids were placed in Resident #25's ears every day as ordered, and the DON was made aware of the concern that one of the hearing aids was missing with no evidence found to indicate that measures were taken to find the hearing aid. The DON acknowledged the concerns at that time and indicated the hearing aid couldn't have gone far as the resident was not someone who would get up and walk. The DON also stated that when a resident lost a hearing aid, the Unit Manager would start the process of conducting a room search, a laundry and a kitchen search, and the staff would search exhaustively prior to notifying the family, and the DON indicated she would look into it.

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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 record review, observation, and interview, it was determined that the facility failed to ensure that a process was in place to ensure that recommendations made by therapy were communicated to and implemented by nursing. This was evident for 1 (Resident #37), out of 1 resident reviewed for position and mobility and 1 (Resident #28) of 3 residents reviewed for activities of daily living. The findings include: 1) On 08/23/24, Resident #37's medical records were reviewed. The review revealed that Resident #37 was a long-term resident of the facility with a history of stroke, right-sided weakness, and decreased right-sided function. On 8/23/24 at 1:27 PM, Resident #37's Occupational Therapy (OT) documents were reviewed. The review revealed an OT evaluation and treatment certification, dated 6/20/24-8/18/2024. Further review revealed a section titled Recommendations: The recommendations included the following: Splint/Orthotic recommendations. It is recommended that the patient wear a hand roll and finger separators on the right hand for up to 6 hours a day, in order to improve Passive Range of Motion (PROM) for adequate hygiene and reduce pain caused by muscle tightening. The above recommendations were made by Occupational Therapist Staff #18. Passive Range of Motion (PROM) is the action in which a part of your body is moved when someone or something is creating the movement. On 8/26/24 at 8:08 AM, an observation of Resident # 37's room was made. Observation revealed a soft hand finger splint laying on top of bedside dresser. On 8/26/24 at 9:24 AM, OT Staff 18 was interviewed regarding the facility's process for implementing OT's recommendation for a splint. During the interview, OT Staff #18 reported that the day shift geriatric nursing assistants (GNA) providing care for the resident needing a splint would be educated. The education would include a return demonstration, on how to apply the splint correctly. Then a therapy communication form with the written recommendations is provided to the nursing unit manager. A copy of this therapy communication form is maintained by the Rehabilitation Director. The expectation is that nursing will put in an order for the splint and if the physician approves of the order, the physician will sign the order. On 8/26/24 at 9:54 AM, GNA (Staff #21) was interviewed. During the interview Staff #21 reported that she had been providing care to Resident #37 on day shift 8/26/24 and she had periodically provided care of him/her in the past. She reported she had never put the hand splint on Resident #37, but she has seen him/her wearing the splint sometimes. GNA #21 reported that there was no place for her to document when Resident #37 wears the splint or when s/he refused to wear the splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 10:05 AM, Nurse LPN, (Staff #22) was interviewed. She reported that she had been providing care to Resident #37 on day shift 8/26/24 and she had provided care to him/her in the recent past. Staff #22 reported that she had never seen Resident # 37 wearing a hand splint. She reported that if a resident had an order for a splint there would be a space to document the use of the splint in the treatment administration record (TAR). During the interview Staff #22 reviewed the electronic TAR and failed to find a space to document the use of a splint. On 8/26/24 at 10:34 AM, a review of Resident #37 failed to reveal a care plan for contracture prevention or splinting. On 8/26/24 at 12:46 PM, Clinical Services Director, (Staff #2) reported that she was unable to provide an order and/or documentation regarding splint recommended for Resident #37. She reported that the expectation is that a therapy recommendation for a splint would be communicated to nursing. Nursing would create the order and then forward the recommendation to the physician. If the physician-approved the therapy's recommendation, they would sign the order. In addition, Staff #2 reported that education of therapy and nursing staff had been started regarding the process and implementation of recommendations by therapy to the nursing staff. 50573 2) Review of Resident #28's medical record revealed the resident was dependent on staff for Activities of Daily Living (ADLs), was not oriented to self, and had a diagnosis of dementia with a BIMS of 4/15. A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS assessment uses a points system that ranges from 0 to 15 points. A BIMS score 0 to 7 suggests severe impairment. On 08/27/24 at 11:00 AM, an interview with the Director of Rehabilitation, who is a Certified Occupational Therapy Assistant (Staff #26), revealed that when long term care residents are determined to be at their highest level of mobility, they are discharged with a Home Exercise Program (HEP). Further interview with Staff #26 revealed that HEPs are recommended for residents to maintain their optimal level of ability and are provided with written exercises if they are capable, as the facility does not have an active restorative nursing program. If a resident was dependent for care, the Physical Therapist would provide verbal training and education on the HEP, with occasional written statements, for the nursing staff to embed into care. The Rehab Director reported there was a nursing communication binder for documentation of nursing staff communication when a resident is discharged with a HEP. He further revealed that they will email the Director of Nursing and the unit manager upon a resident's discharge. During the interview, Staff #26 provided the surveyor with Resident #28's most recent discharge summary from therapy, dated 7/26/24. Review of the therapy discharge summary, from 7/26/24, revealed that Resident #28 had reached her/his highest practical level of mobility and the recommendation upon discharge noted a HEP program. No specifics of what the HEP included were found in the discharge summary. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Rehab Director reported the HEP for Resident #28 was in regard to transfers and getting out of bed. Further interview with Staff #26 on 08/27/24 revealed that, when the surveyor asked to review the nursing communication binder to see the communication when Resident #28 was discharged , Staff #26 indicated that he did not think that there was communication for Resident #28's discharge in the binder. When the surveyor asked if he was aware of what the HEP specifically consisted of for Resident #28, he was unable to recall information nor what the nursing staff would be aware of in terms of the HEP for her/him. The surveyor confirmed with Staff #26 that there was no documentation of the communication provided to nursing staff upon Resident #28's discharge with the HEP. Staff #28 indicated that he would try to find documentation of an email regarding the resident's discharge. On 08/27/24 at 12:37 PM, an interview with Nurse Practitioner (Staff #40) revealed that Physical Therapy initiated the exercises recommended for residents upon discharge and then was the nursing staff's responsibility to implement them into care and if the nursing staff do not implement the recommendations into care, then the residents decline. On 08/29/24 at 01:28 PM, an interview with the Director of Nursing (DON) revealed that the nursing staff were responsible for implementing rehabilitation recommendations into care. On 08/29/24 at 01:42 PM, the surveyor reviewed the concern with the DON regarding the failure to ensure therapy recommendations were documented and implemented by nursing staff upon therapy discharge of a dependent resident. At the time of the survey exit on 8/29/24 at 3:30 PM, there was no documentation provided to indicate what Resident #28's HEP consisted of, nor evidence of nursing communication documentation regarding the recommendations upon Resident #28's discharge from therapy on 7/26/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37276 Based on medical record review and interview, it was determined that the facility failed to evaluate and implement measures to address the resident's nutritional needs as evidenced by 1) failing to ensure that resident weights were obtained timely and as recommended by the dietician following a significant weight loss and 2) failing to ensure the physician was notified timely following a resident's significant weight loss. This was evident for 1 (#15) of 4 residents reviewed for nutrition. The findings include: On 8/16/24 at 12:16 PM, a review of Resident #15's electronic medical record (EMR) revealed documentation that, on 7/11/24 at 12:25 PM, the resident's weight was 296.4 pounds (lbs), and, on 8/7/24 at 1:51 PM, Resident #15 weight was 246.3 lbs which was a 50 lb (16.89 %) weight loss in 1 month, and indicated Resident #15 had a significant weight loss. Further review of the resident's medical record revealed that, on 8/12/24 at 3:10 PM, in a dietary progress note, the dietician wrote that Resident #15's weights were reviewed, that the resident's documented weight of 246.3 lbs was a 50 lb weight loss in 30 days, and that verification of the weight was pending. In a progress note on 8/14/24 at 1:30 PM, the Director of Nurses (DON) wrote that Resident #15 was reviewed in the weekly weight meeting and had a new order for weights every week. Continued review of the medical record failed to reveal evidence that following Resident #15's recorded weight loss on 8/7/24, that the resident had been re-weighed, and his/her weight had been verified. Also, no documentation was found in the medical record to indicate the physician was made aware of the resident's weight loss. On 8/19/24 at 3:30 PM during an interview, Staff #1 (Dietician) was made aware that the documentation in the medical record indicated Resident #15 had a significant weight loss of 16.89 % in one month, and no further documentation was found in the resident's medical record to indicate the weight loss was addressed, that a reweight had been obtained or that the physician had been notified of Resident #15's significant weight loss. In response, Staff #1 stated that Resident #15's weight recorded on 8/7/24 had not been verified and it was highly unlikely that the weight was accurate. Staff #1 stated the resident held a lot of fluid and was at risk for weight fluctuations. Staff #1 indicated that, when a resident had a significant weight loss, the resident was supposed to be re-weighed automatically. When asked why a reweight had not been obtained on Resident #15, Staff #1 indicated it was because following his/her weight on 8/7/24, the resident was transferred to the facility's Covid Unit. Staff #1 stated that during a weekly meeting on 8/7/24, a reweight on Resident #15 was requested, and a reweight on the resident was requested again last week, and she was not sure why Resident #15 had not been reweighed. Staff #1 also indicated the Unit Manager was asked about getting a reweight on the resident, but she was not sure what they were doing. On 8/20/24 at 11:46 AM, a continued review of the medical record revealed that, on 8/19/24 at 4:55 PM, Resident #15's weight was recorded as 238.7 lbs, which was a 7.6 lb weight loss from his/her recorded weight of 246.3 lbs on 8/7/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed on 8/20/24 at 7:49 AM, the dietician wrote that Resident #15's weight was 238.7 lbs which represented a 57 lb (19.5% body weight) loss of past 30 days. In addition, in a SBAR (Situation, Background, Appearance, Review) Communication Form, dated 8/20/24 the nurse documented Resident #15 had a change in condition related to significant weight loss and, on 8/19/24, the resident's weight was 238.7 lbs. The nurse also documented Resident #15's representative was notified on 8/19/24 and the resident's physician was notified on 8/20/24. On 8/20/24 at 2:21 PM, the DON (Director of Nurses), and Assistant Director of Nurses was made aware of the concerns with Resident #15's significant weight loss not being addressed timely, or validated, when identified on 8/7/24, and no documentation found that the physician had yet addressed the resident's significant weight loss of 19.5% in one month. The DON acknowledged the concerns and indicated that the facility had identified concerns with resident weights not being obtained timely and the concern was going through the facility's Quality Assurance (QA) program. On 8/21/24 at 8:55 AM, Staff #49, Corporate Registered Nurse (RN) reported to the surveyor that the physician had been made aware of Resident #15's weight loss and use of diuretics (water pills). On 8/22/24 at 11:20 AM, the Corporate Clinical Director of Nurses Staff #2, provided the surveyor with a copy of a 8/21/24 nurse practitioner (NP) progress note which documented a follow-up visit for Resident #15's significant weight loss. The NP's documented assessment identified the resident's rapid weight loss, that the weight was questionable, and the NP indicated that if Resident #15's weight loss was real, it was most likely multifactorial. At that time, the concerns with the facility staff failing to obtain a reweight on Resident #15 when a significant weight loss was initially identified were discussed with Staff #2, and Staff #2 confirmed the concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 45139 Based on pertinent document review and interviews, it was determined that the facility failed to provide physician services to a resident at least once every 120 days. Based on record review and interview, it was determined that the facility failed to ensure that residents received timely physician visits. This was evident for 1 resident (Resident #92) of 2 residents reviewed for pain management and 1 (Resident #37), out of 6 Residents reviewed for Unnecessary Medications during the recertification survey. The findings include: 1) On 8/23/24 at 10:44 AM, record review revealed that Resident #37 was a long-term resident of the facility. The review of physician notes in Resident #37's record revealed that the resident was seen by a physician twice between 8/01/23 and 8/26/24. On 08/26/24 at 11:36 AM, the Assistant Director of Nursing (ADON) was interviewed regarding the expectations of how often a Physician visits a resident in the facility. The ADON reported that the expectation was that all residents are seen at least every 120 days by a physician. A nurse practitioner usually see the residents monthly. In addition, the ADON confirmed that between 8/01/23 and 8/26/24 Resident #37 was seen by a physician on 2 occasions. She confirmed that Resident # 37 was seen by on 9/3/23 and 6/12/24, and was not seen every 120 days. 48168 2) On 8/23/24 at 2:41 PM, a review of Resident #92's medical record was conducted. The review revealed documentation of monthly visits by a Nurse Practitioner (NP) (Staff #40). No physician visit documentation was found in the electronic medical record. On 8/23/24 at 3:26 PM, an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) was conducted. During the interview, a progress note of a physician visit to Resident #92 by the Medical Director on 2/27/23 was found, but no more recent visits by any physician was found. On 8/23/24 at 3:48 PM in a follow up interview, the ADON said she did not find any other physician notes for the past year so she called the Medical Director who said he had not seen the resident in a year and that he would come to the facility that day to see the resident. On 8/27/24 at 3:19 PM, an interview with the Nursing Home Administrator (NHA) was conducted. When informed that Resident #92 had not had a physician visit for more than one year, the NHA said he was unaware of it and that he understood 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
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 48168 Based on record review and interview, it was determined that the facility failed to ensure that all Geriatric Nursing Assistants (GNAs) had annual performance evaluations. This was evident for 3 GNAs (GNA #11, GNA #13, and GNA #14) of 3 GNAs reviewed during the Sufficient and Competent staffing task portion of the recertification survey. This had the potential to impact all residents. The findings include: On 8/20/24 at 10:00 AM, the annual performance evaluations were requested for GNA #11, GNA #13, and GNA #14 for 2019 through 2023. On 8/20/24 at 1:00 PM, the requested files were received and reviewed and revealed that each file lacked evidence of a performance evaluation in 2022, and GNA #13's file also lacked evidence of performance evaluations in 2020, 2021, and 2023. On 8/23/24 at 9:27 AM, an interview with the Director of Nursing (DON) and the Director of Human Resources (Staff #24) was conducted. They both confirmed the lack of evidence that GNA #11, GNA #13, and GNA #14 had performance evaluations in 2022, and that there was no evidence that GNA #13 had performance evaluations in 2020, 2021, or 2023. They confirmed that this was a deficiency.

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	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 48168 Based on record review and interview, it was determined that the facility failed to post actual hours of nursing staffing. This was evident for 31 of 31 days in July 2024 and 21 of 21 days in August 2024 during the Sufficient Staffing task investigation during the recertification survey. The findings include: On 8/22/24 at 3:54 PM, staff posting documents for July and August 2024 (to date) were requested. On 8/23/24 at 8:33 AM, a record review of staff posting documents for July 1-31, 2024, and August 1-22, 2024, revealed that there were blank spaces on each form where the actual hours for each nursing discipline was to have been recorded. On 8/23/24 at 11:55 AM in an interview with the DON regarding the staff posting documents for July and August, she confirmed that none of the staff posting documents listed actual hours worked and she confirmed that this was a deficiency.

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	215217	A. Building B. Wing	08/29/2024

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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. 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a psychotropic medication prescribed as needed (PRN), had an end date that was limited to 14 days. This was evident for 1 (#95) of 1 residents reviewed for hospice. The findings include: On 8/20/24 at 3:30 PM, a review of Resident #95's medical record revealed the resident was readmitted to the facility in April 2024 following an acute hospitalization . Resident #95 was admitted to hospice in mid-June 2024 with a terminal diagnose of Chronic Obstructive Pulmonary Disease (COPD), and a diagnosis of heart failure. Review of Resident #95's August 2024 Medication Administration Record (MAR) revealed a 6/17/24 order for Lorazepam (Ativan) concentrate by mouth every 4 hours PRN (as needed) for generalized anxiety disorder. The psychotropic medication prescribed to be administered as needed was not limited to 14 days duration, and there was no documented rationale for continuing the order beyond 14 days found in the resident's medical record. The concern with the Lorazepam as needed order failing to have a stop date was discussed with the Director of Nurses (DON) on 8/21/24 at 12:32 PM. The DON confirmed the findings at that time and indicated the facility had a problem with the hospice orders before, which were usually picked up by the pharmacist.

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	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37276 Based on observation, medical record review and interview, it was determined the facility failed to maintain a medication error rate of less than 5%. This was found to be evident based on 4 errors identified out of 25 opportunities for error, resulting in a 16% medication administration error rate. The findings include: 1) On 8/26/24 at 9:10 AM, during an observation of medication administration, the surveyor observed that Staff #16, Licensed Practical Nurse (LPN) dispensed 9 medications into a medication cup, including Acetaminophen 500 mg (milligram), 1 tablet for Resident #41. At that time, Staff #16 reported to the surveyor that Resident #41 had an order for a multi-vitamin which included minerals and iron, that was not available in the medication cart. Staff #16 indicated that s/he would notify the person responsible for ordering the stock medications of the need to obtain the multi-vitamin form that was ordered for the resident. 1a) Following the medication observation, a review of Resident #41's August 2024 MAR (medication administration record) revealed a physician's order for Tylenol Arthritis Pain (acetaminophen) [OTC] tablet extended release; 650 mg; Amount to Administer: 1 tab; oral three times a day. Staff #16 committed an error while administering the medication to Resident #41, by failing to administer the appropriate dose of Acetaminophen medication as prescribed. 1b) Continued review of Resident #41's August MAR revealed an order for Therapeutic-M (multivitamin-iron-fa-calcium-mins) tablet; 9 mg iron- 400 mcg; Amount to Administer: 1 tab by mouth that Staff #16 documented as given. Staff #16 committed an error while administering the medication to Resident #41, by documenting the Therapeutic-M multi-vitamin, which had not been administered to the resident, had been given. 1c) The review of also revealed an order for folic acid tablet, 1 tab by mouth at 9:00 AM, that was documented as given by Staff #16, that was not observed as given during the administration observation. Staff #16 committed an error while administering the medication to Resident #41, by documenting the Folic Acid, which had not been administered to the resident, had been given. On 8/26/24 at 4:24 PM, Staff #2, Corporate Clinical Director of Nursing and Staff #44, Corporate Regulatory Nurse were made aware of the above medication errors and indicated understanding of the concerns. 2) On 8/27/24 at 12:00 PM, during a medication administration, Staff #20, LPN was observed dispensing 2 Sevelamer (Renvela) 2 tablets, in a medication into a medication cup for Resident #51. The nurse was then observed telling Resident #51 that his/her medication was being placed on the resident's overbed tray and instructing the resident to take the medication with his/her lunch. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Following the medication administration observation, a review of Resident #51's August 2024 MAR revealed an order for Renvela 800 mg, 2 tablets one time a day at 11:30 for end stage renal disease. Continued review of Resident #20's physician orders failed to reveal an order to indicate that medication could be left at the resident's bedside. Staff #20 committed an error in medication administration by not observing the resident take the administered medication, instead leaving the medication at the resident's bedside without a physician's order, then documenting the medication was administered as prescribed. The Director of Nurses (DON) was made aware of the above observation at 8/27/24 at 12:36 PM and acknowledged the concerns at that time. On 8/27/24 at 1:20 PM, the DON informed the surveyor that, per physician order, it was okay to leave medication at Resident #51's bedside at 8:00 AM, one day a week, on Monday, Wednesday, and Friday so the resident could be ready for dialysis. The concerns with leaving the medication at the bedside at any other time than the time the physician ordered was discussed with the DON who stated she understood the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 37276 Based on observation, it was determined the facility failed to properly store medication as evidenced by failing to discard expired medications, failing to date medications when opened, and failing to return resident medication to a proper location after adminstration. This was evident for 2 of 5 medication carts, 1 of 1 treatment carts observed during the survey, and 1 complaint (#MD00207855) of 5 complaints reviewed during the recertification survey. The findings include: 1) On 8/23/24 at approximately 2:15 PM, an observation was made of a Potomac 1 medication cart that revealed expired medication: 1a) There was 1 opened bottle of Lantaprost Opthalmic Solution (eye drops) labeled with Resident #108's name and marked an opened date of 6/6/24. Per the Mayo Clinic, an opened bottle of Lantaprost may be kept in the refrigerator or at room temperature for up to 6 weeks. Based on the date the Lantaprost was opened, the medication was expired. The facility failed to discard the discard eye drops 6 weeks after opening. 1b) There was a Bevespi inhaler that was labeled with Resident #15's name and marked as opened on 4/29/24. Per the marked opened date, the inhaler was open for over 3 months and was expired. Per manufacturer's instructions, the Bevespi inhaler should be thrown away 3 months after opening the foil pouch or when the dose indicator reaches zero 0, whichever comes first. The facility failed to discard the medication 3 months after opening. 1c) Inside the medication cart were blue lancets for finger stick blood glucose testing that were not in their original box from the manufacturer. The lancets were not labeled with an expiration date. Because the lancets were not in the box from the manufacturer's, there was no way to know when the lancets expired. Staff #51 was present during the observation of the medication cart and made aware of the findings at that time. 2) On 8/23/24 at 2:25 PM, a locked wound treatment cart with a key attached was observed on Potomac 1. At that time, the Assistant Director of Nursing (ADON) was made aware, opened the cart for the surveyor, and stated the cart belonged in the wound care office and had been brought out for wound care. Observation of the wound treatment cart revealed a tube of Clobetasol propionate topical cream (topical steroid) which was not labeled with a resident's name, which was labeled as opened on 1/10/24. The facility failed to discard the topical medication 6 months after opening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 4/19/24 at 3:51 PM, an observation of a medication cart on Unit 2B revealed an opened Fluticasone Propionate and Salmeterol inhalation powder (Advair Diskus) inhaler labeled with Resident #57's name that was not labeled with the date when opened. According to the manufacturer's instructions the inhaler should be discarded 1 month after opening the foil pouch or when the counter reads 0, whichever comes first. Because the inhaler was not labeled when opened, there was no way to know when the medication expired. Also, in the 2B medication cart, there was an opened Fluticasone Propionate and Salmeterol (Advair) Inhaler labeled with Resident 81's name and the date opened was 2/24/24. The facility failed to discard the medication 1 month after opening as per manufacturer's instructions. At that time, Staff #25 (LPN) who had been present, confirmed the findings and indicated the inhalers would be discarded appropriately. On 4/22/24 at 12:52 PM, the above concerns with failing to discard expired medications and failing to date medications when opened were discussed with the Director of Nursing (DON) and the DON acknowledged the concerns at that time. 48168 On 8/15/24 at 12:08 PM, Resident #92 was interviewed as part of the initial pool screening process of the recertification survey. During the interview, the resident described an incident when staff left an inhaler at his//her bedside overnight. Resident #92 said he/she filed a complaint with the Office of Health Care Quality (OHCQ) about the incident. On 8/15/24 at 2:06 PM, review of complaint #MD00207855 revealed an allegation that on 5/28/24 a nurse left Resident #92's inhaler at the resident's bedside overnight. On 8/22/24 at 11:05 AM, the Director of Nursing (DON) provided 3 incident reports of medication errors for Resident #92. The report described an occurrence on 7/15/24 when an agency nurse (unidentified) left an inhaler at Resident #92's bedside overnight and the next morning it was discovered and reported to the DON. The report also indicated that the agency nurse (unidentified) was placed on Do Not Return status with the facility. On 8/22/24 at 12:10 PM, an interview was conducted with the DON. She said she did not have information about Resident #92's allegation of an inhaler left at bedside on 5/28/24, but she confirmed that the incident on 7/15/24 when an inhaler was left overnight at Resident #92's bedside was a deficient practice.

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	215217	A. Building B. Wing	08/29/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48470 Based on observations, records review and interviews, it was determined that the facility failed to ensure that potentially hazardous food items were cooled according to acceptable standards. This was found to be evident in 2 out of 2 kitchen observations. The findings include: On 8/15/24 at 9:54 AM, an inspection of the kitchens walk-in refrigerator was conducted with the dietary manager (Staff #3). During this inspection, 2 cooked food items were observed with no label. Staff #3 reported that they were chicken fried steak from last night's dinner and sausage patties from this morning's breakfast. Staff #3 indicated that she would label them to fix the concern. Shortly after at 9:57 AM, Staff #3 was asked if the 2 cooked food items were cooled down per regulation. Staff #3 reported that they should have been and indicated that the documentation should be in a binder close to the entrance of the kitchen. After reviewing the binder that contained the cool down log for potentially hazardous foods, Staff #3 stated, it's not done. Then proceeded to instruct a kitchen staff to pull the cooked food items from the refrigerator and indicated that they may not be served. Staff #3 was asked to show prior documentations of staff for the cool down process for cooked food and she indicated that she kept them in a different binder in her office. After checking her binders in her office at 10:05 AM, Staff #3 reported that she cannot find previous cool down logs. Staff #3 reported that whoever the cook was, it was their responsibility to perform the cool down procedures and document the cool down log, she also reported that it was the [NAME] (Staff #4) that should have done that process. On another kitchen observation, the monthly cool down temp binder that contained the form Cool Down Log for Potentially Hazardous Foods was reviewed on 8/28/24 at 12 PM. The latest entries were dated 8/27 for 2 items for pork. The 1st one started the cool down process at 10 AM and the 2nd one started at 10:30 AM. Staff #3 accompanied the surveyor to the walk-in refrigerator for another observation at 12:05 PM. Cooked food items were observed and labeled as: a) Sausage 8/28 b) Mechanical Sausage 8/28 Staff #3 was asked if these items were cooled down per regulation. Staff #3 reviewed the cool down temp binder and at 12:15 PM, she confirmed that there was no documentation that the cool down procedure was performed and reported that the cook was Staff #55. Staff #3 instructed a kitchen staff to discard the items so that they may not be used or served to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11 AM, the concern was discussed with the Director of Nursing, Assistant Director of Nursing, and the Corporate Clinical Nurse that on 2 occasions that the kitchen was inspected, the kitchen staff had failed to ensure cool down procedures were done to potentially hazardous food items observed in the refrigerator. All staff acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48168 Based on record review and interview, it was determined that the facility failed to ensure adequate administrative oversight of 1) nursing staffing, 2) reporting of allegations of abuse, 3) Geriatric Nursing Assistant (GNA) and Licensed Practical Nurse (LPN) training, and 4) clinical services. This was evident for 1) non-compliance with 2 (S670, S680) of 2 state staffing regulations, 2) 6 residents (#6, #9, #19, #25, #67, #92) of 6 residents who alleged abuse, and 3) 6 staff (GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12) of 6 staff reviewed for required in-service training, and 4) 2 complaints (#MD00208809 and #MD00208775) of 7 complaints and for 5 (#MD00206318, #MD00202094, #MD00182597, #MD00205031, MD#00205130) of 34 facility reported incidents (FRIs), reviewed during the recertification survey. These findings had the potential to affect all residents. The findings include: On 8/27/24 at 2:52 PM, the survey team identified substandard quality of care which triggered an extended survey investigation. On 8/27/24 at 3:19 PM, an interview with the Nursing Home Administrator (NHA) was conducted. He stated that he had been in his position for 10 months. When asked how many surveys he had participated in, he replied 40. When asked about his interaction with the governing body, he replied that he gave the governing body monthly reports on all aspects of the facility which were discussed by phone. He explained that he routinely met with marketing, clinical and operational regional staff by phone and sometimes in person. He further stated that the corporation operated 11 facilities in Maryland. When the NHA was asked about how the Director of Nursing (DON) was able to perform all the functions assigned to her, he said that this was her first experience as a DON, and that a more experienced DON would be able to handle all the responsibilities expected of her. He further explained that he just walked into the situation and that he would be leaving soon for personal reasons. 1). When the NHA was asked if he was aware that the facility was non-compliant with state regulations regarding staffing, he said he was unaware of it but that he had submitted a request for competitive wages and referral bonuses to the corporate office. Cross Reference S670, S680 2). When the NHA was asked if he knew the facility did not comply with regulations regarding reporting allegations of abuse, he said he was unaware of it. Cross Reference F607, F609, F610 3). When the NHA was asked if he knew that facility staff lacked required training, he said he was unaware of it. Cross Reference F940, F941, F943, F949. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4). Lack of clinical services oversight was evidenced by findings of 5 incidents of resident abuse or neglect (complaint #MD00208809, and complaint #MD00208775) and (FRI #MD00206318, FRI #MD00202094, and FRI #MD00182597), an incident of immediate jeopardy of resident harm (FRI #MD00205031), and an incident of actual resident harm (FRI MD#00205130). Cross reference F600, F684, F689

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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. 37276 Based on medical record review and staff interview, it was determined that the facility failed to keep complete and accurate medical records as evidenced by an accurate indication for a medication and clinical assessment documentation. This was evident for 1 (#15) of 6 residents reviewed for unnecessary medication and 1 resident (Resident #51) of 1 resident reviewed for dialysis care and services. The findings include: On 8/19/24 at 1:07 PM, a review of Resident #15's medical record revealed that the resident was initially admitted to the facility in June 2019 for long term care, then, readmitted to the facility in April 2024 following an acute hospitalization . The medical record also documented that Resident #15 had multiple diagnoses including extrapyramidal (involuntary muscle movements caused by some psychiatric drugs) and movement disorders, unspecified edema (swelling from build up of fluid in the body), major depressive disorder, and retention of urine (condition of being unable to completely empty the bladder). A review of Resident #15's August 2024 Medication Administration Record (MAR) revealed medication orders that failed to have an accurate indication for use: 1) There was a 4/27/24 order for Benztropine (Cogentin) (treats involuntary muscle movements) tablet by mouth twice a day for diagnosis of psychotic disorder with hallucinations due to known physiological condition. Benztropine medication is used to treat involuntary muscle movements (extrapyramidal symptoms) (EPS) caused by some psychiatric drugs and used to treat the symptoms of Parkinsons disease. Further review of Resident #15's medical record revealed, that on 4/28/24, in a History and Physical (H&P) note, the physician documented Resident #15's medical history included EPS disorder. The indication to use Benztropine medication to treat psychotic disorders was not accurate. 2) There was a 4/27/24 order for Bethanechol (Urecholine) (treats urine retention) one tablet by mouth before meals for diagnosis of other specified extrapyramidal and movement disorders. Bethanechol is a urinary retention medication to treat urinary and bladder problems by emptying the bladder and increasing urination. Further review of Resident #15's medical record revealed that, on 4/28/24, in a H&P note, the physician documented Resident #15 medical history included incomplete bladder emptying. The indication to use Bethanechol for extrapyramidal and movement disorders was not accurate. 3) In the August MAR was a 4/27/24 order for Bumetanide (Bumex) (diuretic) (water pill) tablet by mouth twice a day for diagnosis of Hypotension (low BP). (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bumetanide is a diuretic medication that treats fluid retention and edema and can lower blood pressure. On 4/28/24, in an H&P note, the physician indicated in a physical exam that Resident #15 had bilateral (both sides) lower extremities (legs) edema (swelling caused by too much fluid trapped in the body's tissues). The indication for the resident's use of Bumetanide for hypotension was inaccurate. 4) There was a 6/28/24 order for one Trazodone tablet by mouth at bedtime for diagnose of insomnia. Review of Resident #15's medical record revealed, in a psychiatric progress note on 5/6/24, that the Nurse Practitioner (NP) documented Resident #15's primary diagnoses included recurrent, major depressive disorder and to continue Trazodone for depression. On 6/28/24 at 10:00 AM, in a psychiatric progress note, the NP documented that Resident #15 was seen to evaluate his/her depression, anxiety, mental status and adjust medications for behavioral disturbance. The NP also wrote that, per staff, the resident was sleeping a lot, that when visited by the NP, the resident was sleepy and difficult to arouse with a plan for a gradual dose reduction (GDR) of Resident #15's prescribed Trazodone and antipsychotic. The indication for Resident #15's use of Trazodone was inaccurate as no documentation was found in the medical record to indicate Trazodone was prescribed for insomnia. The concerns related to the inaccurate indications for use of medication were discussed with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 8/20/24 at 2:27 PM. The DON and ADON acknowledged the concerns and offered no further comments at that time. 48168 Dialysis is a treatment that filters and purifies the blood using a machine. This helps keep your fluids and electrolytes in balance when the kidneys can't do their job. A dialysis fistula in the arm is a surgically created connection between an artery and a vein that allows for easier access to the blood for dialysis treatments. Proper care includes feeling the area where the fistula is implanted to ensure it has a check for a pulse or vibration which indicated is it functioning. A bruit is the sound of blood flowing through the fistula, and a thrill is the pulsation of blood flowing through the fistula. On 8/16/24 at 9:32 AM an observation and interview with Resident #51 was conducted as the resident wheeled down the hallway. The resident stated they were on their way to a dialysis center. A dressing on the resident's left upper chest was partially visible and when asked the resident confirmed that they had a catheter for dialysis. The resident further explained that they used to have a dialysis fistula in their arm, but this was removed one year ago, and the chest catheter was placed at that time. On 8/19/24 at 9:05 AM, a clinical record review revealed that Resident #51 had a care plan problem titled [resident #51] is receiving dialysis r/t [related to] ESRD [end stage renal disease]. The associated interventions included Perma-Cath to left upper chest and Monitor RIJ [right internal jugular vein] permacath q [every] shift. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1:08 PM, another record review revealed nursing documentation by Licensed Practical Nurse (LPN #9) dated 8/02/24 at 3:06 PM, which stated, in part, Resident returned safely from dialysis. Stable. No acute problems observed during dialysis. Good thrill and bruit. On 8/20/24 at 11:57 AM, an interview with the Potomac 2 Unit Manager, (Staff #5) was conducted. When asked about Resident #51's nursing care related to dialysis, Staff #5 stated that when the resident returned from dialysis, the resident's vital signs would be taken, the dialysis access checked, and the nurse would document that assessment in the clinical record. Staff #5 confirmed her awareness that Resident #51 had a permacath for dialysis. When Staff #5 was shown the documentation by LPN #9 that indicated she had checked the resident's fistula, Staff #5 confirmed that the documentation was incorrect and could not explain why. When asked, she stated that either she or the Director of Nursing (DON) did chart reviews, but that she was not aware of the incorrect documentation. On 8/20/24 at 2:28 PM, an interview with the DON was conducted and she also confirmed that LPN #9's documentation regarding Resident #51's dialysis access on 8/02/24 was incorrect.

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	215217	A. Building B. Wing	08/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37276 Based on observation and interview, it was determined that the facility's nursing staff failed to follow basic infection control procedures and standard precautions during medication administration as evidenced by 1) failing to perform routine cleaning and disinfection of resident care equipment shared among residents, and 2) failing to follow standard precautions when performing routine testing of blood glucose. This was evident for 3 (#16, #19, #23) of 5 nurses observed for medication administration. The findings include: 1) On 8/26/24 at 8:58 AM, during an observation of medication administration, the surveyor observed Staff #16, Licensed Practical Nurse (LPN) remove a blood pressure (BP) monitor with an attached BP cuff from the medication cart. Staff #16 was then observed using the BP monitor to check Resident #92's blood pressure. Staff #16 then returned the BP monitor to the medication cart. No observation was made of Resident #16 sanitizing the BP cuff prior to use or following its use on Resident #92. On 8/26/24 at approximately 9:10 AM, during an observation of medication administration, the surveyor observed Staff #16 remove the BP monitor and cuff which had previously been used on Resident #92 from the medication cart. Staff #16 was then observed to apply the BP cuff to Resident #41's BP right arm and monitored the resident's BP. Staff #16 then used the BP monitor on Resident #41's left arm. Following the monitoring of Resident #41's blood pressure, the BP monitor was returned to the medication cart. No observation was made of Resident #16 sanitizing the BP cuff prior to use or following its use on Resident #41. 2) On 8/27/24 at 11:05 AM, Staff #19 was observed removing a glucometer device (measures glucose (sugar) in the blood), a disposable blood glucose test strip and a disposable lancet from the medication cart. Staff #19 then tested Resident #15's blood glucose by sticking the resident's finger with the lancet and applying a drop of the resident's blood on a test strip that had been placed in the glucometer. Following the blood glucose test, Staff #19 placed the glucometer back into the medication cart. No observation was made of Staff #19 cleaning the glucometer prior to use on Resident #15 or following its use on the resident. On 8/27/24 at 11:20 AM, Staff #19 was observed removing the glucometer, a disposable test strip and disposable lancet from the medication cart and was then observed testing Resident #20's blood glucose via fingerstick. Following the finger stick, the nurse placed the glucometer into the top drawer of the medication cart. The nurse failed to clean the glucometer prior to use, or after each use or in between residents. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On 8/27/24 at 11:26 AM, Staff #23 was observed removing glucometer, a disposable test strip and disposable lancet from the medication cart. Staff #23 was then observed checking Resident #87 blood glucose via finger stick. Following the finger stick, the nurse placed the glucometer into the top drawer of the medication cart. The nurse failed to clean the glucometer prior to use, or after each use. The facility reused fingerstick devices for more than one resident and the nurse failed to clean the glucometer after each use or between residents. This practice of reusing fingerstick devices could potentially expose residents who required blood glucose testing to the spread of bloodborne infections in the facility. On 8/26/24 at 1:41 PM, during an interview, the Director of Nursing (DON) was made aware of the above concerns with failing to sanitize a blood pressure cuff after use, and the concern that the facility staff failed to follow standard precautions during the performance of routine testing of blood glucose. The DON acknowledged the concerns at that time, and offered no further comments at that time.

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	215217	A. Building B. Wing	08/29/2024

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 48168 Based on record review and interview, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) and Licensed Practical Nurses (LPNs) were offered to receive and be educated about COVID-19 immunization. This was evident for 6 staff (GNA #11, GNA #13, GNA #14, LPN # 9, LPN #10, and LPN #12) of 6 staff reviewed for immunizations during a portion of the infection control investigation during the recertification survey. The findings include: On 8/20/24 at 10:00 AM, the immunization records for GNA #11, GNA #13, GNA #14, LPN # 9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, a review of the immunization records for GNA #11, GNA #13, GNA #14, LPN # 9, LPN #10, and LPN #12 revealed that none of the staff had any evidence that they had received a COVID-19 vaccine or education regarding COVID-19. On 8/22/24 at 4:25 PM, an interview was conducted with the Director of Human Resources (Staff #24) who confirmed that there was no evidence that COVID vaccines were offered or that education on COVID-19 was provided for GNA #11, GNA #13, GNA #14, LPN # 9, LPN #10, or LPN #12. On 8/23/24 at 9:27 AM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) about evidence of staff immunization and education regarding COVID-19 vaccinations. The DON explained that educational materials were posted by the time clock at the staff entrance to the facility. When she was asked for evidence that the education and offer of immunizations had been provided to GNA #11, GNA #13, GNA #14, LPN # 9, LPN #10, or LPN #12, she could not provide any evidence. On 8/29/24 at 11:14 AM, a follow up interview was conducted with the DON, ADON, and the Corporate Nurse (Staff #2) to review the lack of evidence regarding COVID-19 education and immunizations for staff. No further evidence was provided by the end of the survey.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48470 Based on observation and interviews, it was determined that the facility failed to maintain essential equipment in a safe operating condition. This was evident for 1 kitchen observed during the survey. The findings include: On 8/15/24 at 9:47 AM, a tour of the kitchen was conducted with the dietary manager (Staff #3). During the tour, the walk-in freezer was inspected and was observed with icicle formation from the overhead fans extending about 3 feet long. Ice had also formed on the floor below the icicle at about 6 inches high and 5 inches in diameter. Staff #3 confirmed the observation and was taking notes and indicated that she would let maintenance know so that it could be taken care of. On 8/29/24 at 11 AM, the observation was discussed with the Director of Nursing, Assistant Director of Nursing, and the Corporate Clinical Nurse (Staff #2) that the amount of ice buildup in the walk-in freezer did not accumulate overnight and that staff failed to maintain the freezer in a safe operating condition. All staff verbalized understanding and acknowledged the concern.

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	215217	A. Building B. Wing	08/29/2024

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48168 Based on observation, record review and interview, it was determined that the facility failed to accurately assess staff training needs relative to the needs of the resident population of the facility. This was evident for the Facility Assessment reviewed during the extended survey portion of the recertification survey and had the potential to affect residents who receive dialysis care. The findings include: A copy of the Facility Assessment was requested on 8/15/24 during the survey entrance conference. On 8/16/24 at 9:32 AM, an observation and interview with Resident #51 was conducted as the resident wheeled down the hallway. The resident stated they were on their way to a dialysis center. On 8/28/24 at 9:20 AM, a review of the Care Program and Services section of the Facility Assessment indicated that the facility does not care for residents receiving dialysis. A review of the staff education needs portion of the Facility Assessment revealed that dialysis was not listed. On 8/28/24 at 11:36 AM, an interview with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the Corporate Regulatory Nurse (Staff #44) was conducted to review the Facility Assessment. Staff #44 clarified that the facility did not provide dialysis on site, however, the facility did care for residents who receive hemodialysis in an off-site dialysis center. He confirmed that the Facility Assessment lacked a plan to provide staff education regarding the care of residents who receive dialysis. The DON said that she would provide evidence of staff training related to care of residents receiving dialysis. No evidence of staff dialysis training was provided by the end of the survey.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48168 Based on record review and interview, it was determined that the facility failed to provide communication training to staff. This was evident for 3 Geriatric Nursing Assistants (GNA #11, GNA #13, and GNA #14) of 3 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the extended survey investigation of the recertification survey and had the potential to affect all residents. The findings include: On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, the requested employee training records were received and reviewed for the competent staffing investigation portion of the survey. On 8/27/24 at 2:52 PM, it was determined that there was a situation of substandard quality of care and the extended survey task was triggered. On 8/27/24 at 3:37 PM, a review of the employee training records revealed that GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, nor LPN #12 had evidence of the federally required communication training. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any evidence of the required training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of communications training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. They were asked to provide any additional evidence that they may have, but no further evidence was provided by the end of the survey.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 48168 Based on record review and interview, it was determined that the facility failed to ensure that staff were trained about resident rights. This was evident for 2 Geriatric Nursing Assistants (GNA #11, GNA #13) of 3 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the extended survey investigation of the recertification survey and had the potential to affect all residents. The findings include: On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested as part of the Sufficient and Competent Staffing portion of the standard survey. On 8/27/24 at 2:52 PM, it was determined that substandard quality of care existed and the extended survey task was triggered. On 8/27/24 at 3:37 PM, a review of the employee training records revealed that GNA #11, GNA #13, LPN #9, LPN #10, nor LPN #12 had evidence of resident rights training in 2022, 2023, or 2024. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any evidence of the required training for GNA #11, GNA #13, LPN #9, LPN #10, and LPN #12. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of resident rights training for GNA #11, GNA #13, LPN #9, LPN #10, and LPN #12. They were asked to provide any additional evidence that they may have, but no further evidence was provided by 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
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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48168 Based on record review and interview, it was determined that the facility failed to ensure that staff members complete abuse and neglect training. This was evident for 4 Geriatric Nursing Assistants (GNA #11, GNA #13, GNA #14, and GNA #34) of 4 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the annual and extended survey investigation. The findings include: 1) On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, a review of the employee training records revealed that staff lacked annual abuse and neglect training. GNA #11 and GNA #13 lacked abuse and neglect training in 2022. LPN #10 and LPN #12 lacked abuse and neglect training in 2021 and 2022. GNA #14 lacked abuse and neglect training in 2022, and 2024. And LPN #9 lacked abuse and neglect training in 2020, 2021, 2022, 2023, and 2024. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any additional evidence of abuse and neglect training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. They were asked to provide any additional evidence that they may have, but no further evidence was provided by the end of the survey. 50573 2) On 08/21/24 at 11:58 AM, review of Geriatric Nursing Assistant Staff #34's (GNA) employee record failed to reveal documentation that abuse training was completed. On 08/21/24 at 11:59 AM, an interview with Human Resources (Staff #24) revealed the GNA was an agency GNA, they do not have paper records and that what was provided was all she could see online. On 08/27/24 at 02:07 PM, the Director of Nursing confirmed that what was provided is all the facility has. The surveyor reviewed the concern regarding the failure to ensure that nurse aides completed abuse training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48168 Based on record review and interview, it was determined that the facility failed to provide Quality Assurance Performance Improvement (QAPI) training to staff. This was evident for 3 Geriatric Nursing Assistants (GNA #11, GNA #13, and GNA #14) of 3 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the extended survey investigation of the recertification survey and had the potential to affect all residents. The findings include: On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, the requested employee training records were received and reviewed for the competent staffing investigation portion of the survey. On 8/27/24 at 2:52 PM, it was determined that there was a situation of substandard quality of care and the extended survey task was triggered. On 8/27/24 at 3:37 PM, a review of the previously provided employee training records revealed that neither GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, nor LPN #12 had evidence of the federally required QAPI training. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any evidence of the required QAPI training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of QAPI training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. They were asked to provide any additional evidence that they may have, but no further evidence was provided by 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
	215217	A. Building B. Wing	08/29/2024

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 48168 Based on record review and interview, it was determined that the facility failed to provide infection control training to staff. This was evident for 1 Licensed Practical Nurse (LPN #9) of 3 LPNs reviewed during the extended survey investigation of the recertification survey. The findings include: On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, the requested employee training records were received and reviewed for the competent staffing investigation portion of the survey. On 8/27/24 at 2:52 PM, it was determined that there was a situation of substandard quality of care and the extended survey task was triggered. On 8/27/24 at 3:37 PM, a review of the employee training records revealed that LPN #9 lacked any evidence of infection control training. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any evidence of the infection control training for LPN #9. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of infection control training for LPN #9. They confirmed that they could not produce evidence of infection control training for LPN #9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48168 Based on record review and interview, it was determined that the facility failed to provide behavioral health training to staff. This was evident for 3 Geriatric Nursing Assistants (GNA #11, GNA #13, and GNA #14) of 3 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the extended survey investigation of the recertification survey and had the potential to affect all residents. The findings include: On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, the requested employee training records were received and reviewed for the competent staffing investigation portion of the survey. On 8/27/24 at 2:52 PM, it was determined that there was a situation of substandard quality of care and the extended survey task was triggered. On 8/27/24 at 3:37 PM, a review of the employee training records revealed that neither GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, nor LPN #12 had evidence of behavioral health training. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any evidence of the required training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. She stated that the facility did not have a behavioral health training program. On 8/29/24 at 11:14 AM an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of behavioral health training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. They confirmed that the facility did not have a behavioral health training program and did not provide behavioral health training to staff.