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	01/30/2026

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

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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** Based observation and interview it was determined that the facility failed to ensure staff reported environmental concerns to maintenance. This was found to be evident for one out of seven rooms reviewed for potential environmental concerns.The findings include: On 1/22/26 at 2:17 PM while interviewing Resident #5 in the resident's room, the Surveyor heard what sounded like a lawn [NAME] or a chain saw. The resident reported the noise was coming from the window. The Surveyor then observed an approximately 18 inch area of tape on the window and noted the sound was present when the wind blew. The resident indicated the window had been like that for more than several months.On 1/28/26 at 1:56 PM when asked how he monitors items in need of repair, the Maintenance Director (#15) reported they have the TELS system. The Surveyor requested any work orders for Resident #5's window.TELS is a computer-based system used to track building maintenance. Staff that have access to TELS can put in maintenance requests/notifications.On 1/28/26 at 2:19 PM the Maintenance Director reported that there is no open work order for Resident #5's room. The Surveyor then informed the Maintenance Director of the observation of the tape and the sound coming from Resident #5's window. The Surveyor and Maintenance Director then went to the Resident #5's room and observed the tape on the window. The Maintenance Director reported that it was not our [maintenance's] tape and indicated that he would write up a repair order and get the issue taken care of.On 1/30/26 at 1:44 PM an interview with Environmental Services Director (ESD #36) revealed the environmental services staff, including the director, do not have access to the TELS system. If concerns are identified the ESD reported that staff jot concerns down on scrap paper and then let Maintenance Worker (#6) or Maintenance Director #15 know, or they tell me and I'll pass it on. The ESD indicated he tells them verbally or via email. On 1/30/26 at 3:15 PM during an interview with the Nursing Home Administrator (NHA) when asked how housekeeping (environmental services) staff should report concerns to maintenance the NHA responded: through TELS. The NHA then acknowledged that housekeeping staff currently do not have access to TELS. The Surveyor reviewed the concern regarding staff's failure to report environmental concern to maintenance.Cross reference to F 700.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility failed to provide evidence that the resident or the resident's representative was notified in writing of the facility's bed hold and transfer policies at the time of hospital transfer. This deficient practice was identified for 2 residents (Residents #1 and #90) of 4 residents reviewed for hospitalization during the survey.The findings include:1. On 1/23/26 at 1:36 PM a record review of Resident #1's electronic health record revealed Resident #1 was hospitalized on [DATE]. Further review revealed that Resident #1's Power of Attorney (POA) was notified via telephone of transfer as well as the bed hold policy. On 1/28/26 at 11:57 AM, in an interview, Business Office Manager (Staff #17) acknowledged that the hospital transfer policy states that a bed hold notice should be provided in writing to the resident/ resident representative within 24 hours. She could not provide evidence that a written bed hold notice was provided to the resident/resident representative. On 1/28/26 at 12:19 PM, in an interview, Licensed Practical Nurse (LPN # 9) could not provide evidence that written notice was given to the resident/resident representative at time of transfer. On 1/28/26 at 1:39 PM in an interview, the Director of Nursing confirmed that written notice of the bed hold was not provided to the resident/ resident representative. 2. On 1/30/26 at 11:08 AM, the surveyor conducted a record review of Resident #90's medical chart and identified that the resident was transferred to the hospital on [DATE]. The surveyor was unable to locate evidence in the medical record to support that the resident or the resident's representative had been provided with written notification of the facility's bed hold and transfer notices. The surveyor requested that the facility provide evidence of compliance. On 1/30/26 at 11:47 AM, the Clinical Services Director (CSD) stated that the facility was unable to provide evidence that Resident #90 or the resident's representative had been given the bed hold and transfer notices. She stated she believed the business office mailed the original documents but did not scan them into the resident's medical record. On 1/30/26 at 11:51 AM, the surveyor interviewed the Business Office Coordinator (Staff #21), who confirmed she had been asked to mail Resident #90's bed hold and transfer documents but was not instructed to retain a copy of the originals. The Business Office Manager (BOM) overheard the conversation, acknowledged the facility was unable to provide evidence that the bed hold and transfer notices were provided, and stated that, going forward, the documents would be scanned into the medical record and sent via certified mail.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, it was determined that the facility failed to ensure the resident's comprehensive care plan accurately reflected the resident's discharge wishes. This deficient practice was identified for 1 (Resident #75) of 2 residents reviewed for discharge planning.The findings include:A comprehensive care plan is a personalized document that organizes a person's medical treatment, daily support needs, and their exit strategy from long-term care, known as discharge planning.On 1/22/26 at 10:24 AM, the surveyor interviewed Resident #75, who stated they were in a pickle because they wanted to return to the community to work; however, their car was broken and all of their belongings were currently in the facility. When asked whether there was an active plan in place to assist with transitioning from long-term care to the community, the resident stated they were not aware of any such plan.On 1/28/26 at 3:30 PM, the surveyor reviewed Resident #75's discharge care plan dated 12/22/25 and completed by the Social Worker (SW #23), which stated, [Resident's name] has indicated they wish to remain in LTC [long-term care].Additional record review revealed the following social services documentation:On 12/22/25, SW #23 documented, Care plan remains appropriate. Resident wishes to remain in LTC and is interested in the Maryland Medicaid community waiver. Referral has been sent for a lower-level setting.On 12/22/25, SW #23 also documented, in part, Social Services completed the quarterly assessment. The resident's cognition remains intact. The resident expressed motivation to obtain independent housing and demonstrated insight into the need to prioritize his/her health.On 11/26/25, a social services progress note indicated Resident #75 would like assistance finding a shelter or other resources in [area removed for privacy].On 1/29/26 at 3:28 PM, the surveyor interviewed SW #23, who confirmed familiarity with Resident #75 and stated the resident is a complex case with multiple barriers to discharge. She confirmed the resident does wish to discharge to the community at some point. When asked whether the care plan should reflect this goal, she stated it should include the resident's desire to discharge and goals to support that outcome. SW #23 acknowledged the current care plan was not appropriate for Resident #75 and stated, I need to document better. She further stated that while the resident had indicated the facility was the safest place at this time, the resident had repeatedly expressed a desire to work toward discharge.On 1/30/26 at 10:13 AM, the surveyor interviewed the Clinical Services Director, who confirmed that Resident #75's care plan did not reflect the resident's stated wish to discharge to the community and stated the facility was working to update the discharge plan.

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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. Based on record review and interviews, it was determined that the facility failed to provide evidence of coordination of care with hospice services. This was evident for 1 (Resident #19) of 3 residents reviewed for hospice/end-of-life care.The findings include:On 1/29/26 at 5:19 PM, the surveyor conducted a record review of Resident #19 and discovered that the resident was admitted to hospice services on 12/1/2025. Further review revealed that the care plan had been updated to include hospice services and stated: Approach Start Date: 12/01/2025. If using hospice services, the facility will coordinate care approaches, schedules, and tasks with the chosen provider. Created: 12/01/2025. The record also included new physician orders; however, the surveyor was unable to locate hospice communication notes.On 1/30/26 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse (LPN #24) and asked him to explain how communication between hospice services and the facility occurs. He stated, There isn't a communication book. We just receive orders which are dropped off in boxes in the charting room for us to give to the physicians. He reported that the orders are scanned and showed the surveyor an orange binder that contained some of the most recent orders. He further stated, We used to get a file about the residents, which is where the notes for the resident were kept. He explained that since the facility stopped using the mailboxes, staff are now handed new orders or they are left in a bin, and staff are rarely given a report. He stated that communication sometimes occurs verbally.On 1/30/26 at 12:22 PM, the surveyor interviewed the Director of Nursing (DON) regarding the process for hospice communication. She stated that each hospice resident has a purple plastic folder that includes the care plan, standard orders, contact information, and communication documents. The surveyor asked the DON to provide this folder for Resident #19. The DON led the surveyor to the charting room and noted that Resident #19 did not have a communication folder. The surveyor informed the DON that LPN #24 had stated the folder was no longer accessible to staff. The DON confirmed this finding and stated she would add a folder for Resident #19.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on medical record review and interview it was determined that the facility failed to ensure urinary catheter bags were emptied as ordered. This was found to be evident for one (Resident #4) out of two residents reviewed for indwelling catheter usage.The findings include: Review of Resident #4's medical record revealed the resident has an indwelling foley catheter and a history of urinary tract infections. The resident was treated with antibiotics for a urinary tract infection in December 2025. A indwelling foley catheter consists of a flexible tube that is inserted into the bladder via the urethra, and is anchored in the bladder via a small inflated balloon. The tubing allows for continuous drainage of the bladder into a catheter bag. The resident has an order, in place since 10/31/25, to empty foley catheter bag every shift and document the output. Review of the Treatment Administration Record (TAR) revealed an area for nurses to document regarding this order, including a space to document the amount of urinary output. On 1/30/26 at 12:56 PM interview with Nurse #18 revealed that the majority of the time it is the nursing assistants who empty the catheter bag and confirmed this should occur every shift unless the resident refuses. Nurse #18 went on to report that the nursing assistants also document output in their charting, which the nurse has access to, or they can just tell the nurse. Nurse #18 reported she also goes into the resident's room to make sure they emptied the foley (catheter bag). The nurse confirmed she documents resident refusals. On 1/30/26 review of the nurse TAR and the nursing assistant documentation failed to reveal documentation to indicate the resident's urinary catheter bag was emptied as ordered on the 11/21/25 day shift, the 12/20/25 day shift or the 1/9/26 evening or night shift. No documentation was found to indicate the resident had refused to have the urinary catheter bag emptied during these shifts. Review of the TAR revealed Nurse #34 had documented on 1/10/26 at 1:29 AM (this is during the 1/9 night shift), this RN [registered nurse] was not scheduled during time of this task. On 1/30/26 at 1:22 PM surveyor asked Nurse #35 about the note written by Nurse #34 which stated 'this RN was not scheduled during the time of this task. Nurse #35 reported she thought it may have to do with overlapping time schedules, but was not sure and indicated she would go check. On 1/30/26 at 3:15 PM surveyor reviewed the concern with the Director of Nursing and the Nursing Home Administrator regarding the failure to ensure catheter bag was emptied as ordered. No additional information was provided in regard to these concerns prior to survey exit on 1/30/26 at 4:00 PM.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and staff interviews it was determined that the facility failed to provide oxygen therapy per the physician's order. This was evident for 1 (Resident #7) out 1 resident reviewed for oxygen therapy during the survey.The findings include:Oxygen therapy is an intervention of delivering oxygen through a device such as a nasal cannula (small tubes that rest in your nostrils) or a mask. Oxygen therapy is prescribed by a doctor and tailored to each person's needs.On 1/22/26 at 10:26 AM this surveyor observed Resident #7 was receiving oxygen (O2) at 5 liter/minute via nasal cannula.On 1/30/26 at 9:48 AM a record review of Resident #7 Care Plan revealed the resident is at risk for respiratory distress/shortness of breath due to diagnosis of chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and obstructive sleep apnea (OSA). One of the interventions was to administer O2 as ordered. On 1/30/26 at 10:31 AM a record review of physician orders revealed: O2 at 2 liters per minute via nasal cannula. On 1/30/26 at 11:35 AM this surveyor observed Resident #7 with O2 at 5L/minute via nasal cannula.On 1/30/26 at 12:41 PM Licensed Practical Nurse (LPN #19) acknowledged that the physician order for oxygen was O2 2L. On 1/30/26 at 12:45 PM LPN #15 confirmed that Resident #7's oxygen was set at 5 liters. LPN #15 reduced the O2 2 liter/minute. The Director of Nursing was made aware of the concern.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview and record review it was determined that the facility failed to ensure side rails were only used when the resident assessment indicated a need for them and a physician order was in place for their use. This was found to be evident for one (Resident #60) out of three residents reviewed for accidents. The findings include: Review of Resident #60's medical record revealed a diagnosis of dementia and a January 2026 Brief Interview for Mental Status score of 3 out of 15, indicating severe cognitive impairment.On 1/29/26 at 11:31 AM resident was observed sitting on side of their bed, quarter side rails were noted to be in the up position on both sides of the bed.Even when bed rails are properly designed to reduce the risk of entrapement or falls, are compatible with the bed and mattress, and are used appropriately, they can present a hazard to certain individuals, particularly to people with physical limitations or altered mental status, such as dementia or delirium.Review of the facility policy for side rails, titled Enablers with a revision date of 5/5/2023, revealed in the Procedures section: Obtain physician's orders when appropriate; for instance, if a mechanical device is needed. Include medical diagnosis and/or behavior, time frame for use of enabler, and release times, if device is used.On 1/29/26 review of the medical record failed to reveal a current order for the use of side rails. Further review of the medical record revealed a progress note, dated 7/31/25 which stated: Resident no longer requires 1/4 side rails, moving in bed and transferring to w/c [wheelchair] with out device assist, cga [care giver assist]. Order d/c'd [discontinued]. POC [plan of care] updated. Review of the physician orders revealed a corresponding order for two 1/4 side rail to aid with independence in turning, re-positioning, transfers and bed mobility was in place from 5/30/24 until it was discontinued on 7/31/25.On 1/29/26 at 11:49 AM nurse #33 confirmed that the quarter side rails are in the up position on the resident's bed. Surveyor reviewed the concern that the 7/31/25 progress note indicated the resident no longer needed the side rails and that the order was discontinued.On 1/29/26 at 2:17 PM the Maintenance Director #15 reported that when bed side rails are discontinued they use to remove them but then they would be told to put them back on, so now they strap them down.On 1/29/26 at 3:03 PM maintenance worker #6 confirmed that he strapped down the bed side rails for Resident #60 today. On 1/30/26 at 3:15 PM surveyor reviewed the concern with the Director of Nursing and the Nursing Home Administrator regarding the failure to ensure side rails were only used when an assessment indicated their need and ordered by a physician.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, it was determined that the facility failed to ensure staff received education based on findings from their annual performance evaluations. This was evident for 2 (Staff #25 and #26) of 3 Geriatric Nursing Assistants (GNAs) reviewed during the staffing task.The findings include:On 1/28/26 at approximately 10:00 AM, the surveyor reviewed the annual performance evaluations for three GNAs (#25, #26, and #27). The evaluations revealed that both GNA #25 and GNA #26 received a score of 1, defined as Performance Below Standard. Comments included Relias 0% and Needs to do Relias. Relias is the program used by the facility to provide staff education.On 1/28/26 at 1:07 PM, the surveyor interviewed the Nursing Home Administrator (NHA) and expressed concerns regarding gaps in staff education, noting that review of the performance evaluations identified incomplete required training. The NHA acknowledged that there is an issue with staff completing required courses. She stated that she began looking into the matter following the surveyor's request for records and was aware it would be a concern. She reported that she spoke with Human Resources (HR), and they planned to address the issues. She stated that the Assistant Director of Nursing (ADON) is responsible for clinical staff education and that both the Director of Nursing (DON) and ADON are responsible for completing performance evaluations.On 1/28/26 at 2:09 PM, the surveyor conducted a follow-up interview with the NHA, DON, ADON, and HR (Staff #28). The ADON confirmed that she, in conjunction with the facility infection prevention expert, assists with conducting clinical staff education. HR (staff #28) confirmed responsibility for onboarding. However, none of the four staff members were able to identify who was responsible for ensuring nursing assistants receive education related to deficiencies identified in their performance evaluations. The NHA confirmed, and the DON agreed, that there is a systemic gap in ensuring that education addresses weaknesses identified in employee evaluations.

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medical record review and interview it was determined that the facility failed to ensure the pharmacist's monthly medication regimen review identified significant medication errors. This was found to be evident for one (Resident #4) out of six resident's reviewed for unnecessary medications.The findings include: 1) On 1/23/26 review of Resident #4 medical record revealed a diagnosis of diabetes and orders for both long acting and fast acting insulin. The order for the fast acting insulin, with a start date of 10/31/25, included: Humalog KwikPen Insulin (insulin lispro) pen with a strength of 100 units per ml and the amount to be given was per carb intake. The order also included the following Special Instructions: method for calculating insulin coverage. Blood glucose -100=X Round X to the nearest 10th. Give 1 unit of insulin for each 10mg/dL. Resident will continue to calculate with each dose. (example BS is 294. 294-100= 194. Resident to get 19 units of insulin). This insulin was to be administered before meals and at bedtime.Blood glucose is also referred to as blood sugar.Review of the Medication Administration Record (MAR) for January 2026 revealed nursing staff were obtaining and documenting the blood sugar levels (measured in mg/dl) and then the amount of insulin lispro administered. Review of this MAR on 1/23/26 at approximately 9:30 AM revealed multiple wrong dose errors.Examples of these errors included:On 1/1/26 at 11:30 AM the resident's blood glucose level was 304mg/dl and 25 units were administered. According to the order, 20 units were due.On 1/6/26 at 6:30 AM the resident's blood glucose level was 158mg/dl and 0 units were administered. According to the order, 6 units were due.On 1/6/26 at 11:30 AM the resident's blood glucose level was 298mg/dl and 10 units were administered. According to the order, 20 units were due.On 1/8/26 at 6:30 AM the resident's blood glucose level was recorded as low and 9 units were administered.On 1/9/26 at 6:30 AM the resident's blood glucose level was 152mg/dl and 15 units were administered. According to the order, 5 units were due.Further review of the January MAR for 1/1/26 through 1/22/26 revealed more than 30 wrong dose errors out of the 88 times the blood sugar level was due to be checked.Further review of the Medication Administration Record for November and December 2025 revealed multiple similar dosage errors as those found in the January 2026 MAR.Review of the facility's Pharmacy Services Policies and Procedures 1.2 Medication Regimen Review (revision date of 4/17/2024) revealed A written report (either paper or electronic) of all irregularities and recommendations resulting from the medication regimen review are provided to a facility designee for the Attending Physician, Director of Nursing and Medical Director. Examples of a medication 'irregularity' include, but are not limited to, a medication that: .H. Presents as a medication error or the risk for such errors.On 1/28/26 further review of the medical record revealed the pharmacist had completed monthly medication regimen reviews on 11/12/25; 12/15/25; and 1/22/26. The progress note associated with each of these reviews indicated that there were no irregularities in the resident's medication regimen. All three of these reviews were completed by Pharmacist #31.On 1/28/26 at 12:33 PM a phone interview was conducted with Pharmacist #31. The pharmacist confirmed that she looks at Medication Administration Records as part of her monthly medication review. Surveyor reviewed the 10/31/25 order for Humalog KwikPen Insulin (insulin lispro) which inlcuded: Special Instructions: method for calculating insulin coverage. Blood glucose -100=X Round X to the nearest 10th. Give 1 unit of insulin for each 10mg/dL. Resident will continue to calculate with each dose. After this review, and accessing the resident's medical record, the pharmacist stated: I've never seen that before, missed that, if I saw that order I would of said something. Surveyor then reviewed the concern with the pharmacist that multiple medication errors have been identified in regard to this insulin order.2) Further review of Resident #4's medical record revealed the resident was receiving trazodone (an antidepressant medication) for depression. An order was in effect from 12/19/25 until 1/4/26 for two trazodone 100 mg tablets to be given at bedtime. Further review of the medical record revealed a primary care provider note, dated 1/2/26, that indicated the dose was to be (continued on next page)

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	215217	A. Building B. Wing	01/30/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increased to 300 mg based on the resident's report of increased depression. On 1/28/26 review of the Medication Administration Record for January 2026 revealed the trazodone order was for three 100 mg tabs but the Special Instructions stated: Give 2 tabs = 200 mg.On 1/28/26 at 1:45 PM the Assistant Director of Nursing (ADON #16) was interviewed about the resident's trazodone order. After reviewing the trazodone order, the ADON indicated she would have to look at the handwritten order and the nursing note since she was unable to determine what the dose was suppose to be. ADON stated: I will have to go look into that because it is wrong. On 1/28/26 at approximately 2:05 PM the ADON presented with new orders, dated 1/28/26 at 1:56 PM, for the trazodone 100 mg, amount: 3 tabs; Special Instructions: Give 3 tabs = 300 mg. On 1/28/26 at 2:15 PM surveyor and Nurse #33 observed the daily packaging of medication for Resident #4 which indicated two tablets of trazodone were being sent rather than three.On 1/29/26 at 10:24 AM surveyor reviewed the concern with the Clinical Services Director regarding the significant medication errors and the failure of the pharmacist to identify these errors as irregularities.Cross reference to F 760

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review and interview it was determined that the facility failed to ensure residents were free from significant medication errors. This was found to be evident for one (Resident #4) out of six residents reviewed for unnecessary medications.The findings include: 1)On 1/23/26 review of Resident #4 medical record revealed a diagnosis of diabetes and orders for both long acting and fast acting insulin. The order for the fast-acting insulin, with a start date of 10/31/25, revealed a Humalog KwikPen Insulin (insulin lispro) with a strength of 100 units per ml and the amount to be given was per carb intake. The order also included the following Special Instructions: method for calculating insulin coverage. Blood glucose -100=X Round X to the nearest 10th. Give 1 unit of insulin for each 10mg/dL. Resident will continue to calculate with each dose. (example BS is 294. 294-100= 194. Resident to get 19 units of insulin). This insulin was to be administered before meals and at bedtime.According to these special instructions, any blood glucose level above 110 would require an administration of insulin.Blood glucose is often referred to as blood sugar.Review of the Medication Administration Record (MAR) for January 2026 revealed nursing staff were obtaining and documenting the blood sugar levels (measured in mg/dl) and then the amount of insulin lispro administered.Review of this MAR on 1/26/26 at approximately 9:30 AM revealed multiple wrong dose orders. Examples of these errors included:On 1/1/26 at 11:30 AM the resident's blood glucose level was 304mg/dl and 25 units were administered. According to the order, 20 units were due.On 1/6/26 at 6:30 AM the resident's blood glucose level was 158mg/dl and 0 units were administered. According to the order, 6 units were due.On 1/6/26 at 11:30 AM the resident's blood glucose level was 298mg/dl and 10 units were administered. According to the order, 20 units were due.On 1/8/26 at 6:30 AM the resident's blood glucose level was recorded as low and 9 units were administered.On 1/9/26 at 6:30 AM the resident's blood glucose level was 152mg/dl and 15 units were administered. According to the order, 5 units were due.Further review of the January MAR for 1/1/26 through 1/22/26 revealed more than 30 wrong dose errors out of the 88 times the blood sugar level was due to be checked. Additionally, three shifts failed to include documentation to indicate a blood glucose level was checked, or that the resident had refused to have the level checked. Further review revealed that on 1/21/26 the bedtime blood glucose level was documented as 190 mg/dl and 0 units were administered. The nurse documented at 9:16 PM: Not administered; WNL [within normal limits]. The order did not include instructions to hold the insulin if the blood glucose level was below a certain level. No documentation was found to indicate nursing staff contacted the ordering provider for clarification regarding this order, or that the insulin was being held.On 1/23/26 at 9:51 AM surveyor reviewed the insulin lispro order with the Director of Nursing (DON) who reported this was the order the resident had when admitted and that the resident did not want it changed. Surveyor reviewed the concern with the DON that multiple medication errors are evident based on the documented blood glucose levels and the doses administered by staff. The DON indicated she would follow up regarding this concern.Further review of the Medication Administration Record for November and December 2025 revealed multiple similar dosage errors as those found in the January 2026 MAR.On 1/23/26 at approximately 3:30 PM the Clinical Services Director (CSD #20) provided documentation of a Medication/Treatment Error Investigation Report that revealed that sometimes the resident would tell staff to administer an extra 5 units of insulin. Further review of the medical record failed to reveal an order to provide an extra 5 units of insulin upon resident request.Further review of the Medication/Treatment Error Investigation Report revealed, in the section to document steps taken to prevent reoccurrences, that the orders for insulin had been changed to the house sliding scale in addition to 5 units with meals.Further review of the medical record on 1/28/26 revealed that on 1/23/26 at 12:27 PM an order was written to administer an extra 5 units of insulin lispro with meals. The previous insulin lispro order was discontinued on 1/23/26 and a new order was put in at 2:50 PM.The new order was for Humalog KwikPen Insulin (insulin lispro) insulin pen with a strength of 100 units per ml and the amount to be (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given was Per Sliding Scale. The scale included the following: If Blood Sugar is 0 to 179, give 0 units.If Blood Sugar is 180 to 219, give 4 units.If Blood Sugar is 220 to 259, give 6 units.If Blood Sugar is 260 - 299, give 8 units.If Blood Sugar is 300 to 339, give 10 units.If Blood Sugar is 340 to 400, give 12 units.If Blood Sugar is greater than 400 give 12 units; if blood sugar is greater than 400, call MD.2) Further review of Resident #4's medical record revealed the resident was receiving trazodone (an antidepressant medication) for depression. An order was in effect from 12/19/25 until 1/4/26 for two trazodone 100 mg tablets to be given at bedtime. The resident was seen by the primary care nurse practitioner (NP #32) on 1/2/26. Review of the corresponding progress note revealed the resident was reporting increased depression related to a chronic condition as well as inadequate sleep at night. The Plan section of the progress note revealed: Trazodone increased to 300 mg.Review of the orders revealed that on 1/4/26 NP #32 entered an order for trazodone 100 mg, amount: 3 tabs. But the Special Instructions section of the orders stated: Give 2 tabs = 200mg.On 1/28/26 at 1:45 PM the Assistant Director of Nursing (ADON #16) was interviewed about the resident's trazodone order. After reviewing the trazodone order, the ADON indicated she would have to look at the handwritten order and the nursing note since she was unable to determine what the dose was suppose to be. ADON stated: I will have to go look into that because it is wrong.On 1/28/26 at approximately 2:05 PM the ADON presented with new orders, dated 1/28/26 at 1:56 PM, for the trazodone 100 mg, amount: 3 tabs; Special Instructions: Give 3 tabs = 300 mg. ADON went on to report that the NP had put the order in [to the electronic health record] herself and the special instructions was not removed. She also reported that Nurse #33 was following up with the pharmacy to see how much was being sent.On 1/28/26 at 2:15 PM surveyor and Nurse #33 observed the daily packaging of medication for Resident #4 which indicated two tablets of trazodone were being sent rather than three.Review of a 1/5/26 care plan note, written by Nurse #33, revealed: Order received from NP to decrease Trazodone from 200 mg QHS [at bedtime] to Trazodone 100 mg po QHS. Resident and POA [power of attorney] updated with plan of care. On 1/30/26 at approximately 3:51PM Surveyor asked Nurse #33 if there was documentation to support this care plan update that there was a decrease ordered, rather than the increase. On 1/30/26 at 4:00 PM Nurse #33 confirmed that this note was written in error.Further review of the medical record revealed the pharmacist had completed monthly medication regimen reviews on 11/12/25; 12/15/25; and 1/22/26. The progress note associated with each of these reviews indicated that there were no irregularities in the resident's medication regimen. All three of these reviews were completed by Pharmacist #31. Cross reference to F 756On 1/29/26 at 10:24 AM surveyor reviewed the concern with the Clinical Services Director regarding the significant medication errors and the failure of the pharmacist to identify these errors as irregularities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that the facility failed to ensure that medications were secured and stored at the required temperature and that the narcotics were stored in permanently affixed compartments. This deficiency was evident for 1 out of 3 narcotic boxes observed, 1 out of 3 medication refrigerators observed, and 1 medication cart observed during a random observation.1.On 1/27/26 at 2:27 PM, an observation was made of the medication room on the [NAME] Creek unit with Staff #4. Review of the medication refrigerator revealed a narcotic box with a lock on the front side. Further observation showed that the box was not affixed to the refrigerator.On 1/27/26 at 2:29 PM, during a brief interview, Staff #4 reported that the narcotic box could be removed from the refrigerator.On 1/27/26 at 3:54 PM, the Director of Nursing (DON), was interviewed and stated that the expectation was for all narcotic boxes in the medication refrigerators have to be locked and be permanently affixed to the refrigerators.On 1/27/26 at 4:05 PM, an additional observation was made in the medication room with the DON and with Staff #6 (maintenance staff). the DON confirmed that the narcotic box was not permanently affixed and could be removed. The DON reported that maintenance would correct the issue.On 1/27/26 at 4:07 PM, the DON confirmed that it was the expectation for the narcotic box to be attached to the refrigerator and stated that the issue would be corrected.2. On 1/27/26 at 2:38 PM, an observation was made of the Potomac 2-unit medication room. Staff #5 accompanied the surveyor into the medication room and checked the temperature of the refrigerator. Both the surveyor and Staff #5 observed the temperature reading at 50 degrees Fahrenheit.On 1/27/26 at 2:40 PM, Staff #5 reported that maintenance would be notified.On 1/27/26 at 2:40 PM, Staff #5 provided the temperature logs for December and January 2026.On 1/27/26 at 2:45 PM, review of the December Potomac 2 refrigerator temperature log revealed spaces for the staff to record temperatures in the AM and PM of each day. The log included the instruction, Refrigerator acceptable range 36 F-46 F. Record exact temperature twice daily.Further review of the December log showed missing temperature documentation for the following dates: 12/19/26, 12/20/26, 12/21/26, 12/22/26, 12/23/26, 12/24/26, 12/25/26, 12/26/26, 12/27/26, 12/29/26, 12/30/26, and 12/31/26.Continued review of the January 2026 temperature log showed missing entries for the PM of 1/11/26, the PM of 1/12/26 and of 1/15/26, along with both AM and PM of 1/13/26.On 1/27/26 at 2:53 PM, the maintenance staff confirmed that the temperature reading of 50 F by using two thermometers. The maintenance staff reported that the temperature dial of the refrigerator had been set to medium and stated that it would be adjusted.On 1/27/26 at 4:35 PM, the above findings were discussed with the Assistant Director of Nursing (Staff #16). During the interview, Staff #16 confirmed that the expectation was for the medication refrigerator temperature to be documented in the AM and PM every day. Staff #16 acknowledged that the missing documentation was a concern and stated that corrective action would be taken.3.On 1/29/26 at 12:05 PM, an observation was made of the Potomac 2-unit medication cart near the nursing station. During the observation, a resident of the facility, Resident #20, was seen with their hand resting on the edge of the cart. Continued observation showed that Staff #18 was on the opposite side of the nursing station and did not have a direct line of sight to the front of the cart, where the cart drawers could be opened.On 1/29/26 at 12:07 PM, Staff #18 asked Resident #20 to move to a different medication cart to receive medications.On 1/30/26, observation of the unlocked medication cart from 12:05 PM to 12:09 PM, when the DON walked by the cart. The surveyor inquired about the cart, and the DON confirmed that it was not locked. The DON immediately locked the cart and stated that all medication carts should remain locked when unattended.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and interviews, it was determined that the facility failed to ensure concerns identified through the Quality Assurance and Performance Improvement (QAPI) process were addressed through the development of a Performance Improvement Project (PIP). This was evident for 1 of 1 QAPI plans reviewed during the QAA/QAPI task.The findings include:In long-term care, the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) programs are systems designed to monitor care, identify concerns, and implement corrective actions to protect resident health and safety. QAA focuses on identifying and correcting areas of noncompliance, while QAPI uses ongoing data analysis and proactive improvement efforts to prevent problems and improve outcomes. Performance Improvement Projects (PIPs) are structured, team-based initiatives within QAPI used to investigate identified concerns, determine root causes, and implement measurable system improvements.On 1/27/26 at 1:23 PM, the surveyor interviewed the Director of Nursing (DON) and asked her to explain the facility's QAPI program. She stated the facility meets monthly to discuss concerns identified by the QAA committee and confirmed the process is data driven. She informed the surveyor that one of the current concerns discussed in QAPI included annual staff training.On 1/28/26 at approximately 10:00 AM, the surveyor reviewed performance evaluations for GNAs #25, #26, and #27. The evaluations revealed that both GNA #25 and GNA #26 received a score of 1, defined as Performance Below Standard. Comments included Relias 0% and Needs to do Relias (Relias is the program used by the facility to provide staff education). Review of training records revealed multiple instances of incomplete annual trainings (See CMS 2567-F940).On 1/28/26 at 1:07 PM, the surveyor interviewed the NHA and expressed concerns regarding gaps in employee education and that performance evaluations indicated staff had failed to complete assigned courses. She acknowledged that there is an issue with staff completing required courses.On 1/28/26 at 2:09 PM, the surveyor interviewed the NHA, DON, Assistant Director of Nursing (ADON), and Human Resources (HR, Staff #28). None of the four staff members were able to identify who was responsible for ensuring all facility staff completed required annual training. The NHA confirmed, and the DON agreed, that there is a systemic gap in ensuring staff complete annual education.On 1/30/26 at 2:22 PM, the surveyor interviewed the NHA and DON to discuss the facility's QAPI program. During that meeting, the surveyor asked if the quality assurance committee was aware of concerns related to staff not completing annual training. The DON stated they were aware and it was something they had discussed. She stated that they Have been pulling people off the floor to take education when the census drops; however, when asked whether an improvement plan was in place, she confirmed the facility had not developed a Performance Improvement Project (PIP) to analyze the causes or implement solutions to address the lagging education. The DON and the NHA acknowledged that it would be expected for a formal PIP to be initiated when an issue is identified by the quality assurance committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to ensure staff appropriately wore source control (face masks) during a period of increased influenza in the community. This was found to be evident during 6 random observations made on day one of the survey.The findings include: On 1/22/26 at 8:25 AM the survey team entered the facility. Night nurse supervisor #37 reported that due to the high flu rate in the county face masks were currently required. On 12/31/25, the Maryland Department of Health (MDH) issued recommendations in response to increased rates of respiratory virus-associated hospitalizations. MDH advised that healthcare facilities implement facility-wide source control measures in patient care areas and other patient-facing settings. These measures include requiring all individuals-including clinical staff, non-clinical staff, and visitors-to wear masks in patient-facing areas.On 1/22/26 at 10:17 AM the surveyor observed Geriatric Nursing Assistant (GNA #39) coming out of room [ROOM NUMBER] with his mask below his nose. GNA #39 confirmed the mask was below his nose and reported: it was a little bit suffocating.On 1/22/26 at 11:20 AM the surveyor observed GNA #14 in the hallway of the Potomac 2 unit with her mask not worn appropriately to cover both mouth and nose; the GNA was observed adjusting the mask as she entered a resident's room.On 1/22/26 at 11:30 AM GNA #14 was observed in the Potomac 2 hallway with her mask not covering her nose or mouth. Resident #87 and Resident #90 were noted in the hallway at the time of this observation.On 1/22/26 at 11:38 AM GNA #14 was observed in the hallway near the nursing station without a mask on. GNA #14 was then observed entering the elevator without wearing a mask and Resident #57 was also observed entering the elevator at this same time.On 1/22/26 at 12:00 noon GNA #14 was observed providing care to Resident #63 in the resident's room. The GNA's mask was not covering her nose or mouth at the time of the observation. The GNA then came out of the room, acknowledged that the mask should be worn over the mouth and nose, and stated: it was 80 degrees in there, I had to pull it down. GNA #14 then adjusted the mask to be worn correctly.On 1/22/26 at 12:28 PM the environmental service staff #38 was observed on the Potomac 2 unit waiting for the elevator, their mask was below their nose and mouth. ESS # 38 adjusted the mask when approached by the surveyor and reported he was aware of how the mask is suppose to be worn.On 1/28/26 at 11:38 AM the surveyor interviewed the Infection Preventionist Nurse (IP #40). The IP #40 nurse acknowledged that she was aware of the Maryland Department of Health notice about masks. She reported that the current expectation for staff in regard to masks is that anyone on the floor should be masking just to reduce transmission. She confirmed that the masks should be worn in patient care areas including the hallways. The Surveyor then reviewed the concern regarding multiple observations made the week before of staff failing to wear the face masks correctly.

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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. Based on record review and interviews, it was determined that the facility failed to ensure employees completed required annual training. This was evident for 4 (Staff #10, #11, #16, and #29) of 5 staff reviewed for the sufficient and competent staffing task.The findings include:On 1/27/26, the surveyor requested that the Nursing Home Administrator (NHA) provide education records for Staff #10, #11, #16, #29, and #30, as well as annual performance evaluations for three Geriatric Nursing Assistants (GNAs #25, #26, and #27).On 1/28/26 at approximately 10:00 AM, the surveyor reviewed the annual performance evaluations for GNAs #25, #26, and #27. The evaluations revealed that both GNA #25 and GNA #26 received a score of 1, defined as Performance Below Standard. Comments included Relias 0% and Needs to do Relias (Relias is the program used by the facility to provide staff education).Further review of training records for Staff #10, #11, #16, #29, and #30 revealed the following:-Compliance and Ethics Training (F946) was not completed by Staff #10, #11, or #16-Dementia Training (F949) was not completed by Staff #16 or #29Additionally, review of Relias annual education records showed that several assigned courses due had not been completed, as follows:- Staff #10 - Standards of Conduct, Injury and Supervision, HIPAA Level 1, Communicating Effectively, and Managing Elopement (all due 12/31/25)-Staff #11 - Compliance Level 2 training (due 11/30/25) and Managing Elopement (due 12/31/25); completed 2 of 42 courses in 2024-Staff #16 - completed 0 of 44 courses assigned in 2024 and 0 of 2 courses assigned in 2025-Staff #29 - Standards of Conduct (assigned 12/31/24, completed 9/26/25) and 32 incomplete courses for 2025-Staff #30 - completed assigned courses during the onboarding processOn 1/28/26 at 1:07 PM, the surveyor interviewed the NHA and expressed concerns regarding gaps in education for employees and that review of performance evaluations revealed that it was a known issue that staff had failed to take assigned courses. She acknowledged that there is an issue with staff completing required courses. She stated that she started looking into it following the surveyor request for the records and was aware that it would be a concern. She stated that she spoke with Human Resources and that they were going to address the issues.On 1/28/26 at 2:09 PM, the surveyor conducted an interview with the NHA, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Human Resources (HR, Staff #28). The ADON confirmed that she, in conjunction with the facility infection preventionist, assists with conducting clinical staff education. HR confirmed responsibility for onboarding. However, none of the four staff members were able to identify who was responsible for ensuring all facility staff completed required annual training. The NHA confirmed, and the DON agreed, that there is a systemic gap in ensuring staff complete annual education and both agreed that they would work on it.On 1/28/26 at 3:53 PM, HR Staff #28 previously stated she believed additional training records might be available; however, after review, she confirmed that she was unable to locate any documentation and could not provide evidence that staff completed compliance and ethics, dementia, or any other required annual trainings in the Relias program.On 1/30/26 at 2:22 PM, the surveyor conducted an interview with the NHA and DON to discuss QAPI (Quality Assurance Performance Improvement). During that meeting, the surveyor asked if the quality assurance committee was aware of concern over staff not completing annual training. The DON stated that they were aware and it was something that they had talked about. She stated that they Have been pulling people off the floor to take education when the census drops but confirmed that they had not developed a Performance Improvement Project (PIP) that dug into the issues behind why or created solutions to address the lagging education. The DON and the NHA acknowledged that it would be expected that a formal PIP would be created when the facility identifies an issue within the quality assurance committee.