STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 30428 Based on interviews, review of medical records, complaint allegations, and facility policies, it was determined that the facility failed to ensure that staff timely notified resident representatives and physicians of a changes in condition and the occurance of a resident falls. This was evident for 2 (Resident #915 and #900) of 5 residents reviewed for of an allegation of neglect with injuries of unknown origin and 1 (Resident #914) of 11 residents reviewed for falls. The findings include: 1. Review of the complaint related to Resident #915 revealed concerns related to neglect. A comprehensive review of Resident #915's medical record on 7/23/24 at 11:15 AM revealed admission to the facility for their after care related to a fall with fractures. A review of the progress notes documented that, on 5/27/24, Resident #915 was found on the floor in the bathroom. A note was entered on 5/28/24 that the resident's representative was notified, 24 hours later. At the time of the incident, resident was not noted as their own representative and was documented on the physician admission history and physical completed on 4/18/24 as alert and oriented to self only and had a designated medical power of attorney. The facility policy on Change in Condition and Notification was requested on 7/23/24. The concern that there was not a change in condition completed for Resident #915 and the process of notifying the appropriate representatives of a change in condition was reviewed at this time with the Director of Nursing and again on 8/1/24. 2. A. A review of the complaint related to Resident # 900, revealed concerns related to general care received while residing in the facility in 2022. Record review on 7/24/24 at 7:41 AM revealed an incident where Resident #900 complained of knee pain. Resident was treated with Tylenol and then received an x-ray on 7/23/22 due to continued complaints of pain. Per nursing progress notes, the family was not notified until 7/24/22 of the x-ray results, however, in the progress notes, it noted that the family was upset that they were not notified of the injury when it occurred on 7/21/22 after Resident #900 first reported the pain. Record review on 7/24/24 failed to reveal any notification or documentation that the family was notified of the change in condition noted with Resident #900 anytime between 7/21-7/24/22. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. B. The review of the complaint for Resident #900 noted an injury of unknown origin. Record review on 7/24/24 at 7:41 AM failed to reveal that notification to the physician occurred timely when the resident had complaints of knee pain and reported that s/he was bumped into the bed frame during a transfer. There was a delay in getting an x-ray, which occurred on 7/23/22, 2 days after the reported pain. There was no documentation that the physician was notified until 7/23/22, when the nursing staff documented that the resident was crying in pain and his/her knee was observed turned outward, although Resident #900 was treated on 7/21/22 for complaints of new pain with a score of '9,' and regularly thereafter for continued complaints of pain. A facility SBAR (situation, background, assessment) was not completed until the resident was transferred to the hospital on 7/24/22 and there was documentation that the physician was notified that the family requested that Resident #900 transferred to the hospital. When the medical director was interviewed on 7/29/24 at 11:00 AM about notification, he stated that for new pain or changes in condition, he should be notified. According to the facility policy on Change in Condition last reviewed in 2016, 1. the nurse will notify the Residents attending Physician or Physician on call when there has been a. accident or incident involving the resident, b. discovery of injury of unknown source. cross reference F610, F684 40927 3) A medical record review for Resident #914 on 7/26/24 at 2:09 PM revealed a history and physical, dated 4/5/23, that documented the resident had a condition called multiple sclerosis (a chronic disease of the central nervous system that can cause a person to lose the ability to see clearly, write, speak, or walk.), dementia, and frequent falls. Further review revealed that the resident had a fall on the following dates and staff failed to notify the doctor and family: 11/15/23, 12/5/23, 12/6/23, 12/8/23, and 3/20/24. On 3/14/24, a progress note was found that the resident was sent to the hospital for an unwitnessed fall and had hit his/her head. There was no evidence that an assessment or neurological check was completed by facility staff. There was no note that family and the doctor had been notified. An interview with the Medical Director on 7/29/24 at 9:54 AM revealed that, in the Quality Assurance Committee meetings, they had discussed the concern with staff not following the fall protocol. He stated that he was told that it was due to staffing levels. The concerns were reviewed with the Director of Nursing and Regional Director of Clinical Operations on 8/5/24 at 10:29 AM. Reviewed the concerns with the Administrator on 8/5/24 at 11:05 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to protect residents after substantiating that GNA staff that restrained a resident (#926) continued to have access to other vulnerable residents. This was evident during the review of 1of 13 incidents involving abuse. The findings include: On July 31, 2024 At 5:10 PM, an immediate jeopardy was called by the Office of Health Care Quality related to the facility's failure to remove from duty the GNA staff who restrained a resident and continued to have access to other vulnerable residents. A plan to remove the immediacy was accepted on July 31, 2024 at 6:32 PM and abated the following day at 9:30 AM. After the removal of the immediacy, the deficient practice remained at a potential for more than minimal harm with a scope/severity of D for the remaining residents. Review on 7/30/24 at 2:30 PM of the facility reported incident related to a resident being 'secured against the wall ' revealed that per facility investigation and direct observations from other facility staff, Resident #926 was secured against the wall in his/her wheelchair against a table in the sunshine room by facility staff. This resident was unable to independently move him/herself out from the area due to the table being pushed against him/her although s/he normally would be able to move about independently, and at times would use a rolling walker to mobilize around the facility. Resident #926 did have diagnoses including muscle weakness, abnormalities of gait, anxiety disorder and dementia without behavioral disturbances according to the resident's face sheet. Resident #926 was assessed on 3/9/24 to have a brief interview of mental status (BIMS) of 4 meaning that s/he was severely cognitively impaired. Nursing progress notes prior to the incident noted on 3/20/23 that resident is pleasantly confused with various attempts to exit [his/her] wheelchair and walk around. Had to be redirected multiple times .will continue to monitor. Progress notes also stated that s/he was unable to walk 150 feet due to medical condition and safety concerns. However, Resident #926 was actively participating in physical therapy and was documented at a care plan meeting, held a week prior on 3/15/23, as able to walk with supervision 150 feet with a rolling walker for balance support, with the plan for discharge to an assisted living facility. According to a progress note at 12:38 PM on 3/26/23, Resident #926 was noted to be ' non-compliant with his/her walker/wheelchair. S/he was documented as not having a steady gait and shuffles when s/he walks. Staff will assist him/her back to their wheelchair for safety and s/he was also documented as not easily redirected. ' The facility reported incident was documented as occurring around 2PM on 3/26/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This report noted that facility staff found Resident #926 restrained against the wall with a table pushed up against the resident in their wheelchair. On 3/26/23, a ' mood/behavior ' progress note was completed. The resident was documented as walking around hallways and stated to the nurse s/he felt nervous was documented as visibly shaking, and fast paced breathing. This note was written 2 hours after the documented restraint report. The facility nurse practitioner ordered a one-time dose of Buspar, an anxiolytic, as no other interventions such as redirection were working for the noted anxious behavior and anxiety. Prior to this documented incident, Resident #926 had no documented ' mood/behavior ' incidents and did not require any as needed anxiolytics. Interview with staff #8 on 7/30/24 at 2:30 PM, revealed that she observed the incident and immediately notified her supervisor. This supervisor, staff #9, was then interviewed on 7/30/24 at 2:45 PM and confirmed that she too saw the incident and reported it to either the DON or the Administrator, she could not recall who specifically at the time of the interview. She stated that she knows she reported it immediately to nursing as she was not in the nursing department to intervene, but knew it was a concern. Interview with the facility ADON on 7/31/24 at 2:14 PM regarding a substantiated incident of restraining a resident would make the employee a ' DNR ' (do not return). According to the facility reported incident, they noted that 2 staff members had secured the resident in a way that s/he could not move, the resident did not have enough room between the their wheelchair the table and the wall to be able to push the wheelchair back to stand up or propel his/her wheelchair away from the table. Interview with the facility human resources director (HRD) on 7/31/24 at 2:20 PM regarding GNA staff #14 revealed that, for this employee, she was rehired in December of 2023. The HRD had asked the Administrator if there were any concerns as she was not here during staff #14's previous employment. The HRD reported to this surveyor that there were no reported concerns, and if there were, the employee would not have been rehired. The facility reported incident from 3/26/23 was reviewed. The HRD reported that the GNA staff #14 should have been an immediate DNR. During an interview with the Administrator on 7/31/24 at 2:35 PM regarding the incident, it was revealed that staff #14 was rehired. She stated that she didn't know her history and that the previous DON was the one that would have handled any disciplinary action and if it was not in the employee's file, they would not have known about it. The Administrator was notified at this time that there was nothing in the employees file and that she herself was here at the time of the incident and approved for the employee to be rehired in December. Review of the assignment sheets and schedules for the February-July 2024 time frame revealed that employee #14 is continuing to work the 7-3 shift. It was also noted on the assignment sheets that she is responsible for showers. This was also noted that those responsible for showers are responsible for dining in the 'sunshine room' and she worked as recently as the day prior on 7/30/24. The incident that occurred on 3/26/23 was in the sunshine room when Resident #926 was found secured against the wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor interviewed the DON, NHA and RDCO on 7/31/24 at 5:10 PM regarding the second employee involved as they could not locate an employee file with any information in it relevant to this incident. The DON stated that she contacted payroll and was able to locate the agency that was used. The DON then reported that, sometime after this incident GNA staff #15 was made a ' DNR. ' GNA #15's punch card was reviewed at this time showing that she worked until at least 4/6/23, a week after the restraint incident with Resident #926. The concern was raised that this incident did not cause a DNR, however, there was another incident soon after the initial incident that caused the DNR and nothing was documented in the employee file. The DON and NHA were asked if they knew what caused the second DNR situation and the DON stated you have to ask the NHA, as she was not the DON at the time. The NHA was asked, and she did not know. The HRD was asked on 8/1/24 if they had the documentation as to why GNA #14 initially left the facility in 2023, as per the review completed on 7/31/24 there was no documentation. She stated that she had to contact the corporate office for that information. A secure email was received later on 8/1/24 regarding the requested information for GNA staff #14. The paperwork showed that she was terminated on 6/27/2023, that she quit without notice and then was able to return to the facility 6 months later with a pay raise. A plan to remove the immediacy was provided to the survey team on 8/10/24 at 6:09 PM and 6:12 PM and finally a removal plan was accepted at 6:32 PM. This plan included an audit of all current residents to ensure that they were not inappropriately restrained, education to the facility Executive Director and Director of Nursing on ensuring that any employee identified as a perpetrator in any alleged abuse report was immediately suspended pending investigation, which would then be documented in their employee file and the Quality Assurance and Performance Improvement (QAPI) committee would continue to meet to identify root causes of restraint of residents and why employee files were not updated with disciplinary actions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 40927 Based on record review and staff interview, it was determined that the facility failed to ensure that thorough investigations were completed for injuries of unknown origin and allegations of abuse and neglect. This was found to be evident for 5 (Resident #917, #928, # 926, #922, and #900) out of 28 residents reviewed in relation to facility reported incidents. The findings include: 1) A review of the facility's investigation file for facility reported incident #MD00207144 revealed an initial report which read that Resident #917 was found to have a bruise to the right chest, the right inner arm, and on the top of the left 2nd toe. According to Geriatric Nursing Assistant (GNA) #42's statement, she was caring for the resident on 6/26/24 around 9:30 AM, and when she removed the resident's gown, she found the bruising. She also reported that she had cared for the resident on 6/25/24 during the 3 PM - 11 PM shift and the resident had no bruising at that time. GNA #40 who was assigned to the resident on the 11 PM - 7 AM shift starting on 6/25/24 was suspended pending the investigation. Further review of the file revealed that facility staff failed to complete the final report sent to the state agency (SA) by failing to note the alleged perpetrator and provide a summary of the investigation and the findings. Also, they failed to interview the other residents who had been on GNA #40's assignment that night. An interview was conducted on 8/1/24 at 9:00 AM with the Director of Nursing (DON) who conducted the investigation. She stated that it was obvious something happened to the resident however she was unable to determine how the injuries occurred and that GNA #40 was the abuser. She confirmed that she had not interviewed other residents on GNA #40's assignment. Reviewed the final report concerns with her at that time. The concerns were reviewed with the Administrator on 8/5/24 at 11:05 AM. 30428 2) Review of the facility reported incident on 7/30/24 occurring on 3/3/23 regarding Resident #928 having a fall with injury, revealed that the facility failed to have any documentation related to the investigation for this injury of unknown origin related to the resident's fall out of bed. 3) Review of the facility reported incident on 7/31/24 that occurred on 3/26/23 regarding a Resident #926 being restrained in the facility sunshine room, revealed that the facility failed to maintain the investigation into the incident, in addition failed to maintain documentation in the employees' files related to the substantiation of the restraining of a vulnerable resident. 4) On 7/25/24, a review of the facility reported incident related to Resident #922's elopement on on 5/2/23 failed to reveal a facility investigation that included statements, interviews, and education for future prevention. This was confirmed with the facility Director of Nursing on 7/24/24 at 7:17 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) A. During the review of a complaint on 7/24/24 at 7:41 AM, it was noted that Resident #900 had an injury of unknown origin. This injury was not investigated or documented in the medical record. The only documentation in the progress notes was that Resident #900 stated that staff 'bumped [him/her] on the bed frame during a transfer.' Resident #900 was medicated regularly with Tylenol for a high score of '9,' and transferred 3 days later to the hospital with a diagnosis of a tibial fracture. During the attempted review on 7/24/24 of the facility reported incident involving Resident #900 regarding an allegation of abuse, the facility was unable to provide any investigation related to this incident that was reported to the Office of Health Care Quality on 8/9/22. Cross reference F580, F684

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on record review and interview with staff, it was determined the facility staff failed to provide the minimal information required to the receiving provider at the time of transfer. This was evident for one (Resident #924) of four residents reviewed for hospitalization during the survey. The findings include: Review of Resident #924's medical record on 7/24/24 at 12:17 PM revealed that the resident was transferred to the hospital emergency roiagnom on [DATE] for evaluation of lethargy, low blood pressure, and low sodium level. A Hospital Transfer form was not found in the medical record. A Nursing progress note, dated 7/20/22 at 10:36 AM, by the former Director of Nursing (DON) (Staff #20), revealed Resident MOLST [Medical orders for Life Sustaining Treatment], capacity, current med orders, and copy of bed hold policy sent with resident. Resident prepared for transfer. 911 called and resident left facility via stretcher with 2 attendants in stable condition. Report called to ER. However, the note did not indicate that resident's Comprehensive Care Plan goals, identification and contact information for the resident's representative and the practitioner responsible for the care of the Resident #924 were provided to the receiving hospital. No other documentation was found that indicated the required minimal information was sent. On 7/25/24 at 9:05 AM, the surveyor requested a copy of Resident #924's Hospital Transfer form. It was not provided. The Director of Nursing (DON) was made aware of these findings on 7/29/24 at 8:55 AM. In an interview on 7/29/24 at 9:05 AM, the Administrator confirmed there was no Hospital Transfer form or evidence that the required minimal information was sent for Resident #924, to the receiving hospital on 7/20/22. On 7/29/24 at approximately 12:30 PM, the surveyor reviewed the facility policy for Transfer or Discharge, Emergency. The review revealed (C) copywrite date 2001 MED-PASS, Inc. (Revised December 2016) was written at the bottom of the policy. The policy included, but was not limited to: Prepare a transfer form to send with the resident and notify the representative (sponsor) or other family member. The policy included b. Notify the receiving facility that the transfer is being made and d. Prepare a transfer form to send with the resident. The facility policy did not identify the documentation staff were required to send to the receiving facility at the time of a resident's transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30428 Based on medical record review of a facility reported incident and interview with facility staff, it was determined that the facility failed to develop a care plan related to a resident's elopement potential. This was evident for 1 (Resident #922) of 6 residents reviewed for elopement. The findings include: A care plan is a comprehensive and personalized document that outlines the specific needs, goals, and preferences of a patient. Care plans also address the specific services needed to attain and maintain a resident's highest practicable well-being through focus, goals and interventions. The review of the facility reported incident on 7/25/24 regarding Resident #922 revealed a completed elopement assessment on 5/1/23, showing a score of 15, and an actual elopement on 5/2/23, but failed to reveal a care plan related to these findings. A care plan related to these findings was never developed during the resident's 2 week stay in the facility. This was reviewed with the current facility Director of Nursing on 7/25/24 at 9:29 AM who verbalized that a care plan related to this concern should have been developed. cross reference F610, F744

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40927 Based on record review and staff interview, it was determined that facility staff failed to conduct an assessment and neurological checks according to standards of professional practice after a resident had a fall. This was evident for 1 (Resident #914) of 11 residents reviewed for falls. 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. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility 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. Neurological checks is a set protocol to check the resident in set intervals that may include the following; vital signs, orientation, level of consciousness, pupils reaction and size, responsiveness, pain, and checking extremities for strength and feeling. 1) On 7/26/24 at 1:50 PM, a review of the facility investigation file for a facility reported incident #MD00200602 revealed an initial report that noted Resident #914 had been found on the floor with a laceration on his/her head on 12/13/23 at approximately 8:30 AM. S/he was sent to the emergency room for increased confusion. The Emergency Department (ED) report, dated 12/13/23, noted that Resident #914 told the ED staff that s/he had fallen. The CT scan noted the resident had a nose fracture and a fracture of the 9th, 10th, 11th, and 12th ribs. A medical record review on 7/26/24 at 2:09 PM revealed an MDS, with an assessment reference date of 11/24/23, that documented Resident #914 was cognitively intact. Further review revealed that staff failed to complete a head-to-toe assessment and a neurological check of the resident following the fall. 2) On 7/24/24 at 10:02 AM, a review of complaint #MD00205544, dated 5/9/24, revealed that the complainant had concerns regarding Resident #914's frequent falls and that s/he sustained fractures, hematomas, and bruising as a result. A medical record review on 7/26/24 at 2:09 PM revealed a history and physical, dated 4/5/23, that documented the resident had a condition identified as multiple sclerosis (a chronic disease of the central nervous system that can cause a person to lose the ability to see clearly, write, speak, or walk.), dementia, and frequent falls. Review of the resident's progress notes revealed that s/he had falls on 10/22/23, 11/15/23, 12/5/23, 12/6/23, 12/8/23, 3/8/24, 3/14/24, and 3/20/24, however, staff failed to do an assessment and complete neurological checks, when indicated, per standards of practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed that the resident had a fall on the following dates and facility staff failed to notify the doctor and family: 11/15/23, 12/5/23, 12/6/23, 12/8/23, and 3/20/24. On 3/14/24, a progress note was found that the resident was sent to the hospital for an unwitnessed fall and had hit his/her head. There was no evidence that an assessment or neurological check was completed by facility staff. There was no note that family and the doctor had been notified. An interview with the Medical Director on 7/29/24 at 9:54 AM revealed that, in the Quality Assurance Committee meetings, the concern was discussed regarding staff's failure to adhere to the fall protocol which was to assess the resident and conduct neurological checks when indicated. He stated that he was told that it was due to staffing levels. The concerns were reviewed with the Director of Nursing and Regional Director of Clinical Operations on 8/5/24 at 10:29 AM. Reviewed the concerns with the Administrator on 8/5/24 at 11:05 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 31982 Based on review of facility and medical records and interview with staff, it was determined the facility staff failed to provide discharge planning for a resident requesting transfer to another facility. This was evident for 1 (Resident #903) of 28 residents reviewed in relation to facility reported incidents. The findings include: Facility reported incident #MD00203381 was reviewed on 7/25/24 at 9:32 AM. The report included: 3/6/24 & 3/7/24 resident stated to facility Social Worker [he/ she] wanted to return to [another facility], that [he/she's] only at Creekside because [his/her] daughter wanted [him/her] closer to her. This was day 2 and 3 after his/her admission. On 3/7/24 Resident #903 called 911, was transferred to the hospital then discharged from the hospital to another facility. Review of the medical record at that time revealed Resident #903 was capable of making informed decisions on his/her own behalf. The record failed to reveal the Social Worker or other staff acted upon the resident's two transfer requests including any actions taken by the facility staff to address the resident's request. In an interview on 7/25/24 at 1:43 PM, the Director of Nursing (DON) confirmed that the Social Worker had spoken to the resident on two separate occasions in which the resident indicated that he/she wanted to go to another facility. When asked, she indicated that she thought the resident's daughter had spoken to the resident about living closer to her place of work. She confirmed that the resident's medical record contained no information regarding the resident's request to transfer to another facility or how the request was addressed by the Social Worker or other facility staff. The Social worker (Staff #19) was interviewed on 7/29/24 at 8:58 AM. She recalled the resident and stated the resident was adamant that [he/she] did not want to be here, wanted to be in [another facility]. She was made aware that the surveyor was unable to find documentation in the medical record that the facility staff addressed the resident's request. She indicated she would look at her notes and get back to the surveyor. At 11:50 AM on 7/29/24, the surveyor asked the Administrator to provide evidence pertaining to any measures the facility took to arrange/address discharge/transfer of Resident #903 to another facility when requested by the resident. No additional information/documentation was provided. On 7/29/24 at approximately 1:00 PM, the Social Worker confirmed that she was unable to find evidence that the facility addressed the resident's transfer requests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50573 Based on record review, interviews, and observations, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADL) were provided with showers. This was evident for 2 (#59 and #64) of 4 residents reviewed for ADL. The findings include: 1) A review of MD00196837 from September 2023 revealed an allegation that Resident #59 only had two showers in two months since their admission in July 2023. A review of the MDS, with an assessment reference date of 10/12/23, revealed that Resident #59 needed partial to moderate assistance with showers. Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. On 08/02/24 at 8:32 AM, the surveyor requested the shower task sheet for July 2023 to October 2023 for Resident #59. On 08/02/24 at 10:06 AM, an interview with the Director of Nursing (DON) revealed she was not able to provide documentation of showers for Resident #59 from July 2023 to October 2023. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern regarding the facility's failure to ensure that a resident needing assistance with ADLs was receiving regularly scheduled showers. 48259 2) In an interview on 7/24/24 at 10:37 AM, Resident #64's representative reported that the resident was supposed to receive showers twice a week in the mornings; however, the staff was not providing them. A medical record review found that Resident #64 was admitted to the facility in April 2024 with diagnoses that included Dementia. Continued review revealed an admission MDS assessment, dated 4/14/24, for Resident #64. The MDS had recorded that Resident #64 had moderate cognitive impairment and was dependent on staff for all his/her self-care needs. A review of the shower book and Geriatric Nursing Assistant ADL documentation for Resident #64 from May 1 to June 30, 2024, was completed on 7/25/24 at 9:16 AM. The review showed a record of showers on 5/4/24, 5/18/24, 5/20/24, 6/3/24, 6/11/24, 6/13/24, and 6/20/24. Bed baths on 5/2/24, 5/7/24, 5/8/24, 5/9/24, 5/12/24, 5/15/24, 5/16/24, 5/22/24, 5/23/24, 5/25/24, 5/28/24, 5/29/24, 5/30/24, 6/2/24, 6/12/24, 6/16/24, 6/18/24, 6/21/24, 6/23/24, 6/25/24, 6/29/24. Staff had documented N/A (not applicable) on 5/11/24, 5/13/24, 5/17/24, 5/24/24, and 5/27/24; the remaining days were left blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 7/26/24 at 10:57 AM of Resident #64 lying in bed and staff #50, a geriatric nurse aid providing care to the Resident. Staff stated, I'm here trying to wash [him/her] up. In an interview on 7/26/24 at 2:51 PM, staff #50 stated, Let me be honest with you, sometimes you only have time to complete the basics, which doesn't include showers. With the number of residents, we are responsible for, sometimes it's impossible to give showers. Staff continued to confirm that Resident #64 did not receive his/her scheduled shower. During an interview on 7/30/24 at 7:57 AM, the director of nursing confirmed that Resident #64 did not receive his/her shower as scheduled on 7/26/24. The DON continued to state that Resident #64 was expected to have showers twice a week on Tuesday and Friday mornings, meaning that he/she would receive 8 showers monthly and bed baths on the non-shower days. However, the record review earlier showed that the Resident only received 3 showers and 13 bed-baths in May, 4 showers and 8 bed-baths in June.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40927 Based on observation, record review, and interview, it was determined that the facility failed to recognize and address changes in the condition of residents. This was evident for 2 of 14 residents reviewed for hospitalization s and quality of care. (#127 and #921) This failure resulted in an immediate jeopardy. The findings include: 1.On 7/23/24, upon entry to the facility, Resident #127 was observed sitting in a wheelchair in a common area near the nurses' station. A medical record review on 7/25/24 at 9:08 AM revealed that the resident had returned from the hospital 7/19/2024. Review of the orders revealed that, on 7/19/24, the resident was ordered a Hospice evaluation (end-of-life care) and Morphine 0.25 mg by mouth every 3 hours for pain. Review of the progress notes revealed that, on 7/19/24 at 5:13 PM, a pharmacy alert was sent stating, This order is outside of the recommended dose or frequency. Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 0.25 MG/5 ML by mouth every 3 hours for Pain. However, there was no documentation that staff called the physician to review this alert and clarify the order. Review of the medication administration record for July 2024 revealed the following order: Morphine Sulfate Oral Solution 20MG/5ML Give 0.25ml by mouth every 3 hours for Pain. The morphine was administered to Resident #127 on the following dates and times: 7/21/24- 12am, 6am, 9am, 12pm, 3pm 7/22/24- 9am, 12pm, 3pm, 7/23/24- 12am, 3am, 6am, 12pm, 3pm, 6pm, 9pm 7/24/24- 12am, 3am, 6am, 9am, 12pm, 3pm, 6pm 7/25/24- 12am, 3am, 6am, 9am Further review revealed that Licensed Practical Nurse (LPN) #2 wrote on 7/25/24, that the resident had been started on intravenous fluids (IV), that the patient was nonverbal but responded to touch. There was no other documentation about the resident's decline. There was no documentation that the doctor, family, or Hospice Care was notified of the change. Review of assessments revealed that no change in condition had been documented. Review of meal percentages for intake revealed that the resident had been eating 76% - 100% between 7/19/24 - 7/22/24 to eating 0% - 50% on 7/23/24. Then on 7/24/24 and 7/25/24, the resident was eating 0% - 25%. However, staff failed to notify hospice or the physician about this change and or investigate a possible cause of the change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LPN #2 revealed the resident was bed bound, and not eating and drinking. For this reason, she had called the resident's family who requested IV fluids, so she called the attending physician to get the order. An interview with the DON on 7/25/24 revealed that she was not aware that the resident was on morphine routinely. The DON was asked where the resident care policies and procedures were located, she reported that she does not have access to the resident care policies and procedures. She stated she knew they were electronic, but had to ask the Administrator to print them for her. An interview with the Administrator and [NAME] President of Clinical Operations (VPCO) on 7/25/24 revealed that staff had an icon on their computer desktop to access the resident care policies and procedures. The VPCO stated she was going to check to make sure they had the icon and provide education. The DON reported that when the employee's desktops were reviewed for the resident care policy icon, it was not present. A follow-up interview with the DON on 7/26/24 revealed that she had reviewed the resident's discharge summary and found that the attending physician [who was the physician who cared for the resident in the hospital] had ordered the morphine as it was entered in the orders. She reported that those orders were verified with the attending physician on the day of admission by the admitting nurse. She stated that, with these findings, she talked to the attending physician, and he stated that the morphine order was supposed to be as needed and not routinely. The DON reported that the morphine order had been changed to as needed versus routinely. An interview with the attending physician on 7/29/24 at 9:54 AM revealed that he had mistakenly put in the Morphine as a routine medication versus as needed. Furthermore, when the admitting nurse confirmed the orders with him, he failed to catch the error. He stated that the pharmacist and nurses should review the orders to check for errors. He reported that an RN or unit manager was supposed to review all new admissions to check orders and clarify them if there was a concern. When informed that a pharmacy alert had been in the progress notes, he stated nursing had not notified him regarding the alert. He stated that when Resident #127 was admitted to the facility, he observed the resident in the dining room with family eating a meal. When staff notified him that the resident was not eating and drinking and the family requested IV fluids, he stated he thought about the resident's medications, but was unsure of the cause of drowsiness. However, he did not further look into this concern, He reported that, if he had been aware of the error in the Morphine order, he would have realized that was causing the resident's drowsiness. When asked how the resident was doing now that the medication was corrected, he stated the resident was sitting up and visiting with family. After surveyor intervention, a subsequent observation on 7/29/24 at 11:35 AM revealed the resident was in a wheelchair, self-propelling in the hallway. The resident was observed interacting with staff. A medical record review revealed on 7/29/24 the morphine order was changed to as needed. On 7/26/24 the resident intake was back to the normal of 76% - 100%. A review of the medical record on 8/1/24 at 11:30 AM revealed a progress note written on 7/31/24 at 3:51 PM that read the resident was being discharged to assisted living. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	30428 2. Record review on 7/23/24 at 12:25 PM for Resident #921 revealed that, around 12/8/2022, Resident #921 began complaining of abdominal concerns. Mylanta was ordered at that time. Further review revealed around 1/7/2023 that Resident #921, according to the progress notes, presented as tearful and had complaints of pain in their right lower abdomen. There was noted dimpling and with some hardened areas with pain that had been going on for approximately 2 weeks duration. S/he was also having some loose stools and was given loperamide. On 3/3/23, Resident #921 was having more nausea, vomiting and dizziness and was refusing meals for over 3 days. S/he was noted as pale with cool skin. S/he was ordered Reglan and omeprazole for the nausea and vomiting but unable to always take medications. There was an order at that time to send him/her to the emergency room for evaluation. The resident went and returned that day. Resident #921 was seen on 3/4/22 by the attending for follow up to the hospitalization and nausea and vomiting. There were no new interventions or plans for the resident according to the attending physician's note. He noted that s/he may need a gastrointestinal evaluation if not improved and if symptoms worsened. He was asked on 7/29/24 about the following up of consultations and he acknowledged that this was not completed. On 3/9/23, Resident #921 was seen by the nurse practitioner (NP). Staff were reporting s/he was refusing meals, had weight loss (approximately 30 lbs. at this point over the past few months) was on Reglan, but still had nausea and vomiting and was refusing medications. The intervention order was for a GI consult, however, that was not put into the resident's order set until 3/22/23. Interview with the DON on 7/25/24 at 2:08 PM revealed that the consult was never completed. According to a change in condition completed on 3/21/23, the nurse documented that she reported to the NP that Resident #921 was still complaining over the past few weeks regarding nausea, vomiting, abdominal pain, heartburn, sleeping more often, not wanting to get OOB, refusing medications and refusing meals. The NP ordered a nutritional consult. This was completed on 3/31/23, however, the dietitian still noted that s/he continued with weight loss and more nausea and vomiting. On 4/2/23, Resident #921 was sent to the emergency room for a change in mental status. S/he was placed on a non-rebreather. Within 2 hours of the emergency room admission, the hospitalist notified the family that they needed to admit him/her to hospice as there was nothing further that could be done. The general diagnosis was sepsis, shock and circulatory failure. The resident passed away within 48 hours. The facility medical director was interviewed on 7/29/24 at 10:42 AM regarding this resident. He stated that this was an unfortunate incident. He further stated that if there is an ongoing medical issue he does follow up with the ordered consults. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these findings, a state of immediate jeopardy (IJ) was declared on 7/29/24 at 2:07 PM and an IJ summary tool was provided to the facility at that time. The facility submitted a plan to remove the immediacy on 7/29/24 at 6:57 PM and the facility's written plan to remove the immediacy was accepted on 7/29/24 at 7:10 PM with an alleged date of compliance of 7/30/24. The immediate jeopardy was abated the following day on July 30, 2024 at 9:30 AM. The provisions of the plan to remove the immediacy included the following: Resident #921 no longer resided in the facility. Resident #127 was assessed on 7/29/24 for any changes in condition with updates to the physician if indicated, a medication review was completed and any discrepancies identified were corrected immediately. Current facility residents were assessed starting on 7/29/24 and will be completed on 7/30/24 to identify if there has been a change in condition and that the physician has been notified in a timely manner with appropriate interventions initiated if indicated and that documentation of the change in condition is present in the medical record. Current facility residents with new onset of complaints of pain or injuries of unknown source over the last 30 days were reviewed on 7/29/24 to ensure that results were reviewed timely by the physician and that if indicated, an investigation was started if the facility could not identify the source of the injury present. Current facility residents' medication orders were reviewed with the pharmacy consultant and attending physician to ensure that orders were correct and appropriate for the resident and that any pharmacy alerts had been addressed. Current facility residents' orders for consults over the past 30 days were reviewed to ensure they have been carried out or scheduled as ordered. Facility licensed nurses received education starting on 7/29/24 (to be completed by 7/30/24) from the Director of Nursing on ensuring that residents are promptly assessed for any change in condition and ensuring that the physician was notified with documentation in the medical record along with implementing interventions in a timely manner, ensuring that physician orders with pharmacy alerts were addressed and the physician notified for changes to orders, if applicable. Staff members who did not receive the required education by 7/30/24 were to be educated prior to beginning their next shift. The facility Medical Director was re-educated on 7/29/24 by the Corporate Medical Director on the roles and responsibility of ensuring that residents are appropriately assessed for a change in condition with appropriate interventions and received follow up as indicated if the condition persists or worsens, that diagnostic tests are reviewed in a timely manner, that residents receive medication reviews according to physician and pharmacy standards and that ordered medications are reviewed with changes made if indicated by the pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The QAPI committee will continue to meet to identify the root causes, and to initiate improvements to the facility's processes and procedures ensuring that all residents are promptly assess for any changes in condition and ensuring that the physician is notified with appropriate documentation in the medical record along with implementing interventions in a timely manner, ensuring physician orders (especially related to narcotic orders) with pharmacy are addressed and physician notified for changes to the orders if applicable. Ensuring that diagnostic tests are completed and reviewed in a timely manner by the physician. If the diagnostic test reveals an injury of unknown origin the facility must investigate per regulation. Audits will occur weekly x [times] 4 weeks, biweekly x2 months, then monthly x2 months to ensure the facility remains in compliance. On 7/31/24 at 8:00 AM, after validation of the implementation of the facility's plan of removal, which included staff interviews, record reviews and direct observation, it was determined the facility met the minimum standards of compliance to remove the findings of an Immediate Jeopardy on 7/31/24 at 9:30 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45139 Based on pertinent document review, observation, and interview, it was determined that the facility failed to implement preventative measures to prevent pressure injuries. This was evident for 4 residents (Resident #25, #47, #2, #75), out of 43 residents reviewed during a survey. The findings include: 1. On 7/26/24, the review of medical records for Resident #25, a long-term resident at the facility, revealed that the resident had a recently healed stage 3 pressure injury on the buttocks. A stage three pressure injury is when the full thickness of the skin is lost. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. On 7/26/24 at 10:10 AM, the Director of Nursing (DON) was interviewed regarding the facility's documentation for the turning and positioning of a resident to prevent pressure injuries. The Director of Nursing (DON) reported that the facility considers turning and repositioning part of the standard of care and that there was no order for turning and repositioning, nor documentation when turning and repositioning is done. The DON reported that she does not conduct any audits to ensure that turning and positioning of residents at risk for pressure injury was being done. Turning and repositioning patients is a strategy to prevent pressure injuries (PIs) by reducing pressure on areas at risk, maintaining circulation, and keeping skin healthy. This can help prevent bedsores, also known as pressure injuries. This allows offloading of a specific part of the body. Offloading is pivotal in facilitating healing and preventing injury reoccurrence by alleviating pressure from affected areas. On 7/29/24, multiple observations were made of Resident #25 in her/his room. Observation revealed the following: 7:35 AM Resident # 25 lying in bed on his/her back, the buttock area was not offloaded, and the resident's heels were lying on the sheets against the mattress. 7:59 AM Resident # 25 lying on his/her back with the Head of Bed (HOB), slightly inclined, the buttock area not offloaded. The resident's heels were lying on the sheets against the mattress. 9:01 AM Resident # 25 lying on his/her back with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets, against the mattress. 9:45 AM Resident #25 lying on his/her back with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets. A small wedge pillow was on the bedside table. 10:29 AM Resident # 25 lying on his/her back, flat in bed, buttock area not offloaded. The resident's heels were lying on the sheets against the mattress. A small wedge pillow was lying on the bedside table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10: 53 AM Resident # 25 lying on his/her back, flat in bed, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. A small wedge pillow was lying on the bedside table. 11:35 AM Resident # 25 lying on his/her back in bed with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 12:30 PM Resident # 25 was sitting up in bed with their lower extremities (LE), on the mattress, eating lunch, with the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. The small wedge pillow was under the resident's right arm. 1:07 PM Resident #25 was on his/her back with the HOB at a slight incline, a wedge pillow under their right arm, LEs on the bed and the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 1:30 PM Resident # 25 lying on his/her back in bed with the HOB and Foot of Bed (FOB) slightly inclined, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 2:30 PM Resident # 25 on his/her back, in bed with the HOB slightly inclined, buttock area not offloaded. The resident's heels were lying on the sheets. On 7/29/24 at 2:35 PM, GNA #21, who was assigned to provide care to Resident #25, was interviewed regarding how she turns and repositions a resident. She reported that a resident is turned and repositioned by turning the resident first to face the window, then turning to face the door, and then to lie on their back. In addition, the resident's heels are floated (kept from rubbing against the bed) The GNA reported that Resident #25 had been turned and repositioned during the day shift (7-3) on 7/29/24. On 7/29/24, the surveyor and GNA #21 observed Resident #25 in his/her room. The observation revealed Resident # 25 lying on his/her back in bed, the HOB slightly inclined, and the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. GNA #21 reported that the one pillow provided was not thick enough to raise the resident's legs off the bed to prevent the resident's heels from rubbing against the sheets and mattress. In addition, she reported that the small wedge underneath the resident's arm is not enough to keep the resident on his/her side. GNA #21 reported that the resident was difficult to reposition. On 7/29/24 at 2:35 PM, the LPN (Staff #2) providing care to Resident #25 was interviewed. She reported that Resident #25 had been turned and repositioned on 7/29/24 during the day shift. Then she reported that the surveyors' observations of the resident remaining on her/his back were because the resident gets agitated and is difficult to keep in a certain position. On 8/1/24, a review of the resident's progress notes from 7/29/24 through 12:00 PM 8/1/24 failed to reveal documentation that the resident refused to be turned or repositioned, or that s/he was unable to be turned and repositioned. On 8/1/24, a review of Resident #25's current care plan failed to reveal that the resident was difficult to turn and reposition or refused to be turned and repositioned. Further review revealed the resident was to be encouraged to turn and reposition with rounds every 1-2 hours and PRN (as needed) as tolerated and the wound was to be offloaded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 10:17 AM, the facility's wound care Physician (Staff #27) was interviewed. He reported that Resident #25 recently had a healed pressure injury on the buttocks. He reported that his recommendations were to turn and reposition the resident every 1-2 hours, if possible. He reported that the nurses had not reported any difficulty with pressure injury interventions for Resident #25. On 8/01/24 the Director of Nursing (DON) provided a facility policy titled Turning a Resident on His/her Side Away from You, dated 2010. A review of the policy section under documentation revealed the following should be documented in the resident's medical records: any problems or complaints made by the resident related to the procedure, If the resident refused the treatment, the reason(s) why and the interventions taken. On 8/01/24 at 3:35 PM, during an interview with the Corporate Clinical Director, (Staff #16) and the Director of Nursing (DON) regarding the above concerns, no further information was provided concerning pressure injury prevention and care. 2. On 7/26/24, a review of complaint #MD00181130 revealed a concern that some residents at the facility were being provided incontinence care by using 2 briefs instead of one. On 7/31/24 at 5:34 AM, GNA (Staff #28), reported that Resident #47 requested that 2 diapers be put on him/her. A brief interview with Resident #47 at 5:36 AM, confirmed that the resident did request to wear 2 briefs. The GNA confirmed that Resident #47 was wearing 2 briefs. 3. On 7/31/24 at 5:53 AM, GNA (Staff #28), was observed exiting Resident # 2's room with a trash bag. GNA #28 reported she had just completed incontinent care for Resident #2. Further observation of the trash bag revealed one brief and one pull-up. GNA #28 confirmed that Resident #2 was wearing one brief, and one pull-up before receiving incontinent care. On 7/31/24 at 5:54 AM, during a brief interview with GNA #28, GNA reported that residents pee a lot, maybe because they are on medications that make them pee a lot sometimes have a diaper and brief on. 4. On 7/31/24 at 6:19 AM, CMA/GNA (Staff #29) was interviewed. During the interview, she reported that around 3:00 AM, she provided incontinent care to Resident #75. CMA/GNA #29 reported that before providing incontinent care, Resident #75 had a brief under a pull-up and an additional brief on the bed lying under the resident. On 7/31/24 at 10:17 AM, the Director of Nursing (DON) was interviewed regarding incontinent care. She reported that the expectation is that GNAs check for the need for incontinent care every 2 hours. She reported that it is never appropriate to double brief, even if the residents asked for 2 briefs. The DON reported she was aware that this had happened in the past and had provided on-the-spot education to correct the issue. On 8/01/24, The Director of Nursing provided a copy of an On the Spot of Education dated 5/3/2024. A review of the education document revealed that 11 staff members attended the education. Further review revealed the following instructions: EFFECTIVE IMMEDIATELY: Toileting/Incontinence Care rounds are to be done every 2 hours. Please reposition the resident in bed also at this time this causes skin breakdown. NO DOUBLE BRIEFS ALLOWED! Thank you.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30428 40927 Based on record review and interview with facility staff, it was determined that the facility failed to have a process in place to ensure that staff 1.provided care in a manner to ensure residents were not injured. 2. provide safe equipment for residents and 3. provide care in a safe and professional manner. This was evident during the review of 1 (Resident #928) of 5 falls with injury. This deficient practice resulted in harm to resident #9 and resident #928. This was evident for 1 (#9) of 10 residents reviewed for accidents/hazards. The findings include: On 7/23/24 at 9:13 AM, a review of complaint #MD00206718 revealed that Resident #9 had been brought to the Emergency Department (ED) for treatment of a 15-centimeter (cm) leg laceration on the lower right leg. The complainant reported that the facility was unable to tell them what happened to cause the injury. The complainant reported that the resident stated that staff were transferring him/her from their wheelchair to the bed and something caught his/her leg, cutting it open. A review of the facility ' s investigation report, on 7/23/24 at 3:15 PM, revealed that, on 6/14/24 around 11:00 PM, 2 agency geriatric nursing assistants (GNA) #22 and #23 transferred Resident #9 from the wheelchair to the bed. The resident stated his/her leg hurt. When the GNAs took off the resident ' s pants, they found a large laceration that was gaping open with adipose tissue exposed. However, they were unable to say how the laceration occurred. A review of Resident #9 ' s hard chart, on 7/23/24 at 9:47 AM, revealed a history and physical dated 4/21/22, and documented by the attending physician, that stated the resident had come to the facility for rehabilitation after a hospitalization due to a fall. A medical record review, on 7/23/24 at 10:31 AM, revealed that the last attending physician ' s note was dated 6/17/22. On 7/25/24 at 1:41 PM, review of physical therapy notes for the treatment dates of 3/30/24 - 4/26/24 revealed the resident was non-ambulatory and required a mechanical lift for transfers. Further review of the medical record revealed a change in condition documented by LPN #2, for Resident #9, dated 6/14/24, that noted the resident had a deep skin tear. A review of the requested hospital ED visit notes for 6/14/24 on 8/1/24 at 8:35 AM revealed that the resident reported to the ED staff that, during a transfer from his/her wheelchair to the bed, s/he fell and cut his/her leg on the bed. The resident had a 15 cm laceration on the right calf that required 4 internal stitches and 30 external stitches to repair it. Surveyor attempted to interview Resident #9 on 7/23/24 at 9:27 AM, but the resident was unable to recall how s/he injured their leg. An interview on 7/23/24 at 1:00 PM with the Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO) was conducted. The DON reported that after investigating the incident, she thought the resident had caught his/her leg on the two metal pieces that stabilize the footrest on the wheelchair. The DON brought the wheelchair to the interview room for inspection. The top metal piece had a rough area, but the wound was vertical and in a C shape and the metal piece ran horizontally. The DON failed to recognize this as an injury of unknown origin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 2:14 PM, an interview with GNA #22 via a phone call, revealed that she was not assigned to Resident #9 that day. GNA #22 reported she was asked by GNA #23 to assist her with transferring the resident from the chair to the bed. She stated that both of them transferred the resident by standing on each side of the resident and pivoting the resident into the bed. GNA #22 reported that the transfer was fine but then the resident stated his/her leg hurt and when they looked, they found the laceration. The surveyor attempted to interview GNA #23 by phone on 7/23/24 at 2:55 PM and 7/25/24 at 11:48 AM and left a message, but the GNA did not call back. An interview with Licensed Practical Nurse (LPN) #2 on 7/25/24 at 9:25 AM revealed that, on 6/14/24, she had responded to GNA #22 and #23 yelling for assistance. She reported that when she went into the room the resident had a large laceration on his/her right leg that was fileted open. She stated neither of the GNAs were able to tell her what happened, nor was the resident. She stated that there was some blood on the floor but was unable to find any on the chair or the bed. LPN #2 showed the surveyor a picture of the laceration that was taken on a staff cell phone to send to the DON. Observation of the picture showed a large laceration that the skin was laid back and subcutaneous tissue (layer of tissue below the layers of skin) was exposed. LPN #24 was interviewed on 7/25/24 at 9:41 AM. She reported that she was assigned to Resident #9 that evening shift. She reported that she responded to the GNAs yelling for help around 11:00 PM. When she entered the room, she saw the gaping laceration on the resident ' s leg and the GNAs were unable to say how it happened. She reported she looked on the floor, bed, and the wheelchair looking for blood and was not able to find any. A subsequent interview with the DON on 7/25/24 at 9:54 AM revealed that the facility utilized agency staff frequently. However, there was no formal orientation given to the agency staff prior to their first shift. The DON reported that the expectation was for the agency staff to sign on to the computer and access the Kardex to determine the care needs of their residents prior to starting their care and receive a report from the off-going GNA while walking from room to room. The DON was uncertain how the new agency staff would know these expectations. When concerns had been identified, the agency staff on duty have been educated, but there was no process to ensure that all agency staff were aware of the expectations to ensure resident ' s needs were provided in a safe manner. The DON reported that, when she was made aware of the incident with Resident #9 on 6/14/24, she went into the resident ' s Kardex and found that the information on how to transfer the resident had been removed due to a computer programming glitch. If GNA #22 had known to check the Kardex to see how to transfer the resident, the information would not have been available. The DON failed to interview the GNA #22 to determine the reason she had transferred the resident in the manner that she had. An interview with the attending physician (who is the Medical Director) on 7/29/24 at 9:54 AM revealed he was aware that Resident #9 had sustained a laceration during a transfer. When shown the photograph of the laceration, he reported that this type of injury would not occur during a routine transfer from a wheelchair to a bed. He stated it was likely the resident ' s leg was caught on something and pulled. 2) A facility reported incident regarding a resident (#928) falling out of bed on 3/3/23 during activities of daily living (ADL) care and sustaining a hematoma was received and reviewed on 7/30/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #928 had an admission diagnosis including morbid obesity, fluid overload, muscle weakness, and cellulitis of the bilateral lower legs. According to Resident #928 ' s medical record, s/he was assessed on 3/2/23 functionally as needing extensive assistance requiring 2-person for bed mobility which includes how the resident moves from a lying position and turns side to side, and total dependence of one person for bathing which excludes washing hair and back. According to the facility report while GNA staff #12 was bathing Resident #928, she asked the resident to roll over. The resident was rolled over away from the GNA. As Resident #928 grabbed the mattress to hold on, s/he rolled off the bed onto the floor. Staff were immediately notified and acquired a hoyer to assist Resident #928 back into bed. S/he was assessed by the nurse on duty and documented as having a hematoma on his/her forehead, since s/he was on a blood thinner, an order was made to send the resident to the emergency room for evaluation. On the facility report, the results of the investigation noted that the NHA and previous DON immediately had inspected the bed and noted that the mattress was larger than the bed frame, in addition the GNA had inappropriately rolled Resident #928 away from herself not safely towards her. On 7/24/24 at 7:17 AM the current DON had followed up with the survey teams and reported that there were multiple facility reported incidents that their team was unable to locate from 2022 and 2023, that included this one. The only investigative information related to this incident was what was available in the initial and the 5-day investigation reported to the State.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45139 Based on interviews, and record reviews, it was determined that the facility failed to accurately document a resident's dietary consumption to ensure the resident received adequate nutritional intake. This was evident for 1 Resident (Resident #12) out of 3 residents reviewed for nutrition during the survey. The findings include: On 8/2/24, intake #MD00208140 was reviewed. Review revealed a concern that Resident #12 did not receive adequate nutrition. Further review revealed that Resident #12 was admitted for rehabilitation. On 8/2/24 at 1:52 PM, review of the dietician progress note, dated 7/11/24, revealed that Resident #12 received nutrition by mouth (PO) and, through a feeding tube. Further review revealed the registered dietician was monitoring the resident's PO intake and prescribing tube feedings based on Resident #25's weight and his/her PO intake. On 8/2/24 at 11:15 AM, Registered Dietician (RD) Staff # 25, was interviewed via phone. Staff #25 reported that she had monitored the percentage of meals the resident had eaten at every meal. She continued that, if the resident's PO intake fell below 50 percent eaten at each meal, she would adjust the tube feeding to provide additional nutrition. Staff #25 reported she obtained the information regarding how much the resident had eaten from reviewing the Geriatric Nursing Assistant (GNA) task documentation. On 8/2/24, the GNA task documentation of Resident #12's PO intake for July 1st through July 22nd of 2024 was reviewed. The review revealed 66 opportunities (meals) to document the percentage eaten. Further review failed to reveal any documentation of what Resident #12 had eaten for 23 out of 66 opportunities (meals) during that time period. The following dates and times failed to have any documentation of Resident #12's PO intake: 7/1/24 at 12:00PM 7/2/24 at 8:00AM & 12:00PM 7/3/24 at 8:00AM & 5:00PM 7/4/24 at 5:00PM 7/5/24 at 8:00AM & 12:00 PM 7/6/24 at 8:00AM & 12:00 PM 7/7/24 at 8:00AM & 12:00 PM 7/8/24 at 5:00PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/10/24 at 5:00 PM 7/11/24 at 8:00AM & 12:00 PM 7/12/24 at 8:00AM & 12:00 PM 7/15/24 at 5:00 PM 7/18/24 at 8:00AM & 12:00 PM 7/20/24 at 8:00AM & 12:00 PM 0n 8/2/24 at 12:00 PM, the above concerns were discussed with the Director of Nursing (DON). The DON failed to provide any evidence that the GNAs documented Resident #12's food intake on the above dates and times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 45139 Based on observation, interview and record review, it was determined that the facility failed to 1) administer respiratory therapy (oxygen) according to professional standards and 2) maintain respiratory care equipment for residents who required continuous oxygen via nasal cannula. This was evident for 2 (#25 and #68) of 2 residents reveiwed for respiratory care. The findings include: 1) Resident #25 was a long-term resident of the facility with a history of chronic obstruction pulmonary disease (a chronic lung disease, that can make it difficult to breath). On 7/26/24 at 9:50 AM, review of the medical record revealed the following orders: An order with a start date of 4/10/24, Check O2 sat every shift, (oxygen saturation rate) and an order with a start date of 4/10/24, for 02 L/min via nasal cannula, as needed, for SOB [shortness of breath] related to Chronic obstructive pulmonary disease. Please indicate when 02 has been applied. See nurse notes for detail. On 7/29/24, multiple observations were made of Resident #25. Observations revealed that the resident was on O2 via nasal cannula at the following times: 7:35 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 7: 59 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 9:01 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 9: 45 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 10:30 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 10: 53 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 11:35 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 12:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 1:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 2:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 9:55 AM, Resident #25's Treatment Administration Record (TAR), for the month of July 2024, was reviewed. The review revealed a space to document the time and date of the resident's O2 saturations, and if they received oxygen. Further review of the documentation, failed to demonstrate that Resident #25 received oxygen on 7/29/24. On 7/29/24 at 12:28 PM, LPN Staff #2 was interviewed regarding how the Resident #25 was administered oxygen. During the interview, she reported that she was currently providing care to Resident #25, and s/he was on continuous oxygen, except for short periods of time when the resident removes the nasal cannula. On 8/1/24 at 3:35 PM, the above concerns were discussed with the Director of Nursing (DON) and the Regional Director for Clinical Operations/services (Staff #16). The DON confirmed that the documentation in the TAR, failed to accurately reflect the resident's oxygen use. On 8/1/24 at 2:41 PM, the DON provided an updated oxygen order. Review of the oxygen orders revealed that the order for oxygen, as needed was discontinued. Further review revealed a new order for Resident #25 was to receive continuously oxygen, via nasal cannula. 48259 2) An observation on 7/23/24 at approximately 8:40 AM during the initial tour of the facility showed Resident #68 lying in bed and receiving 2 Liters (L) of continuous oxygen via nasal cannula. The observation found no humidifier water attached to Resident #68's oxygen concentrator. A prefilled humidifier with sterile water is used with oxygen concentrators to offer comfortable humidity and moisture to continuous flow oxygen therapy to prevent upper airway dryness. A subsequent observation on 7/24/24 at 9:03 AM showed that Resident #68 continued to receive 2L of continuous oxygen via nasal cannula with no humidification. Resident #68 was interviewed at that time. During the interview, he/she stated that he/she asked the nurses several times for the humidification water, but no one provided one. A medical record review showed an attending provider's order for Resident #68 for oxygen at 2L via nasal cannula continuously every shift for shortness of breath. In an interview on 7/24/24 at 9:34 AM, staff #24, a licensed practical nurse, reported that before admitting an oxygen-dependent resident, she was expected to have ready a concentrator, oxygen tubing, and sterile water for humidification and then obtain an attending provider's order for changing the tubing and water weekly. During an interview on 7/24/24 at 10:18 AM, staff #56, a registered nurse, stated that humidification water should be attached to Resident #68's oxygen. Staff #56 stated that she was unsure why the resident did not have it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 10:20 AM, staff #57, a nursing supervisor, reported that an admitting nurse was expected to obtain orders from an attending provider to change the oxygen humidification water weekly. However, an earlier review of Resident #68's medical record failed to show an attending provider's order for oxygen humidification. An observation made later the same day showed a humidifier bottle prefilled with sterile water attached to Resident #68's oxygen concentrator after the surveyor's intervention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48259 Based on record review and staff interviews, it was determined that the facility failed to ensure that a resident received pain medication according to an attending provider's order and failed to document pain assessments to include the location of the pain and type of pain for a resident reporting pain. This was evident for 1 (#64) of 1 Resident reviewed for pain management. The findings include: A pain scale is 0-10; 0 means no pain, and 10 represents the worst pain. It is used to assess the level of pain a patient is experiencing for better treatment. Non-pharmacological pain management is an intervention without the use of medications. A review on 7/25/24 at 1:25 PM of complaint record #MD00208061 indicated that Resident #64 was usually in pain; however, staff failed to assess and manage his/her pain. A medical record review on 7/2524 at 2:30 PM showed that Resident #64 had been residing in the facility since April 2024 with diagnoses including cervical spine fracture. The review also noted that the resident had pressure sores on both buttocks and his/her sacral area. A subsequent review on 7/25/24 at 5:08 PM showed a provider's order, dated 4/9/24, that directed staff to assess Resident #64's pain every shift and offer non-pharmacological interventions including, but not limited to, hot/cold compresses, repositioning, and turning before administering medication. Then, document the non-pharmacological interventions attempted before giving PRN medications. Further review showed another provider's order, dated 5/13/24, for pain medication to be administered to Resident #64 every 4 hours PRN (as needed) for pain. A review of Resident #64's medication administration record (MAR)for July 2024 was completed. The MAR had recorded that the nurses administered oxycodone 5mg to Resident #64 on 7/14 for a pain level of 9, 7/17 for a pain level of 1, 7/24 for a pain level of 6, 7/27 for a pain level of 8 and 7/28 for a level of 10. However, the review failed to show a record of Resident #64's pain assessment, including the location, type of pain, and non-pharmacological intervention implemented before administering pain medicine. In an interview on 7/30/24 at 11:20 AM, staff #24, a licensed practical nurse, stated that before she administered any PRN medication to a resident, she would first offer a non-pharmacological intervention like massage or repositioning, then provide the medication if that didn't help resolve the pain. In an interview on 8/01/24 at 10:58 AM, the assistant director of nursing (ADON) checked Resident #64's progress notes and then stated that there was no documentation to accompany what happened on 7/14, 7/17, 7/24, 7/27, and 7/28. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON continued to say that the provider's order for a nonpharmacological intervention before administering a medication was not followed through. She also reported that her expectation of the nurses was to include their assessment of the resident's pain in their notes, including the location and type of pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 30428 Based on medical record review, interview with complainants and facility staff, it was determined that the facility failed to have a process in place to ensure that physician notes were available in the medical record and failed to ensure that a review of the residents' total treatment was completed each visit. This was evident for 4 (Resident #911, #921, #9 and #914) of 6 residents reviewed for quality of care during a complaint survey conducted during the recertification survey. The findings include: 1) Review of the complaint for Resident #911 on 7/25/24 revealed concerns with his/her admission to the facility and the availability of their medications. A comprehensive review of their hospital discharge on 7/31/24 at 7:46 AM revealed discharge medications to include a regimen of Lasix, a diuretic, 1 tablet of 40 mg Tuesday-Thursday and Saturday and Sunday, while receiving 2 tablets of the 40 mg on Mondays and Fridays for edema. S/he was also ordered pain medication, hydrocodone-acetaminophen every 6 hours as needed for pain. A comparative review of the hospital discharge orders, and the admission orders noted that the Lasix order was entered and corrected 4 times with the final order entered still incorrect, ordering Resident #911 double the dose of 80 mg of Lasix every day, instead of just 5 days a week. Additionally, according to admission orders and the medication admission record, Resident #911's Synthroid, ordered for thyroid replacement was ordered and administered at the wrong dose of 100mcg instead of 125 mcg, which was administered for the first 2 days of his/her stay. The Medical Director was interviewed on 7/29/24 at 10:44 AM. Multiple concerns were brought to his attention at this time regarding history and physical notes that included medications that he had documented as receiving that they were not. His reasoning for the discrepancies on his admission notes was that his reports pull the residents medications from 'Epic' which is the hospital electronic record and does include all medications that the resident has received while a patient in the hospital, and may not reflect medications received or receiving while in the nursing home facility. 2) A record review of Resident #921's electronic health record (EHR) was initiated on 7/23/24 at 10:25 AM related to a complaint about the care they received during their stay in the facility from 2022-2023. At the time of the review, there were no physician notes physically or electronically available in the medical record, they needed to be requested by the surveyor. The physician notes for the time frame of January 2023 through April 2023 were requested on 7/24/24 and provided the same day from the Director of Nursing who acknowledged that they were not on either the electronic or the paper chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes completed by the facility medical director's Nurse Practitioner (NP-1,Staff #5) that was documented as occurring on 1/12/23, noted that the residents' medications were last reviewed on 10/3/22. Included in this list were 28 medications all noted as 'filled.' In this list included medications that were 'filled' as late as 2/8/23, 4 weeks after the documented assessment. Additionally, the medications listed included multiple medications that the resident was no longer taking, including a steroid from 12/20/21, and duplicate medications of Lasix listed at 20 mg and 40 mg and 3 different antibiotics that were 'filled' from June and July of 2022 that Resident #921 was no longer receiving. The progress note continued that there were no concerns from the nursing staff at the time and further documentation noted: the assessment plan; medically stable, continue present meds and care. The encounter was co-signed by the medical director on 3/11/23. Resident #921 was seen again on 1/19/23 by the same staff NP-1. She documented that the medications were reviewed. This list contained the same list of medications as in the list from the 1/12/23 visit. The progress note stated that the resident was medically stable and participating in physical therapy with no complaints from the nursing staff. Resident #921 was documented as seen on 3/9/23. The progress note completed by the same staff NP-1, documented that the medications were not reviewed and last reviewed on 1/19/23. Again, the same medications were listed. This progress note documented that the resident was recently hospitalized for ongoing vomiting and nausea, that staff had reported the resident was refusing meals, with a weight loss of approximately 30 lbs. The entry continued that the resident was on Reglan but continued to complain of nausea. This Reglan order was initiated on 3/3/23, however, was not listed as a current medication for the resident Interventions noted to continue current care and all medications as directed, but will need to refer out to gastroenterology due to nausea and vomiting despite nausea meds. This progress note was documented as signed on 3/23/23, despite the resident being seen on 3/9/23. The order for the gastroenterology consult was not documented into the resident's order set until 3/22/23. Resident #921 was seen again on 3/30/23 by NP-1. The medications were documented as reviewed on 1/19/23, with the same list noted as prior and still not including the Reglan that was added on 3/3/23. The assessment and plan for this visit noted; patient doing well, continue current regimen and all meds as directed. Medically stable. This note was signed on 4/15/23. In the meantime, Resident #921 had already been transferred to the hospital on 4/2/23 and was transferred into hospice for sepsis, shock and circulatory failure, passing away on 4/4/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the medical director on 7/29/24 at 10:41 AM revealed that the medications and information on the physician progress notes are prepopulated and the information including the residents' demographics, medications and diagnoses are pulled from the hospital information that the medical director has access too, not necessarily the most up to date diagnosis and medications the resident was receiving while residing in the nursing home. This surveyor reviewed the concern that it was documented throughout the notes that the medications were reviewed, that they were incorrectly documented and that at other visits, it was clearly documented that the medications were not reviewed even though it is the responsibility of the medical director to to review the total plan of care at each visit. The medical director was asked about the notes not being reviewed and updated on the medical record. He stated that he would give them to the NP who would bring them in. He had no other reason for the physician notes not to be on the chart timely. 40927 3) On 7/23/24 at 9:47 AM a review of Resident #9's paper record revealed a history and physical (H&P) conducted on 4/21/22. The attending physician (AP) documented the resident was admitted for therapy due to a disclosed fracture of the right shoulder and trouble swallowing. In addition, the resident had high blood pressure, high cholesterol, and diabetes. 3a) The H&P dated 4/21/22 read that the resident was on the medications as ordered and did not include the medications orders. Review of the note dated 5/31/22 revealed that the following orders (that were in the facility's EMR) were not listed in the note: Enoxaparin Sodium Solution, Cyanocobalamin, enema, oxybutynin, aspirin, docusate sodium, and acetaminophen. This indicated that the total plan of care was not reviewed during this visit. The resident was readmitted in July 2024 and an H&P was conducted by the AP on 7/19/24. Review of the notes revealed the AP documented he reviewed the resident's medications however, review of the facility's EMR revealed that no orders were entered until 7/20/24. The orders in the facility's EMR did not match those that were included in the physician's notes. An interview with the AP on 7/29/24 at 9:54 AM revealed that his EMR pulled information from the hospital's medical records and therefore the medications and treatment records may not match what was in the facility medical records. He failed to review the resident's total plan of treatment and ensure it was accurately depicted in his notes. 3b) An electronic medical record (EMR) review for Resident #9 on 7/31/24 at 9:58 AM revealed 3 AP notes had been uploaded: The visit dated 6/17/22 was not uploaded until 8/9/22, the visit dated 8/4/22 was not uploaded until 8/9/22, and the visit dated 7/19/24 was not uploaded until 7/29/24. The nurse practitioner's (NP) notes were not uploaded between 7 days to 3 months after the visit date. On 7/31/24 at 10:30 AM review of AP and NP notes provided by the facility as they had not been in the medical record revealed that 5 visits conducted by the AP in 2022, and 3 visits conducted in 2023 had not been uploaded into the medical record. There were 15 visits conducted by the NP in 2022 and 8 visits in 2023 that had not been uploaded in the medical record. These notes were not immediately available to staff caring for the resident to review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) A review of the EMR for Resident #914 on 7/26/24 at 10:26 AM revealed in the miscellaneous tab noting that the physician note dated 4/5/23 had not been uploaded into the EMR until 8/24/23. The NP notes had not been uploaded in a timely manner: the 4/6/23 visit was uploaded on 8/25/23, the 9/7/23 visit was uploaded on 9/29/23, the 9/21/24 visit was uploaded on 9/28/23, and the 3/8/24 visit was uploaded on 4/4/24. On 7/31/24 at 10:30 AM a review of the physician and NP notes that were printed by the medical records staff from the physician's medical record system revealed that 8 visits had not been upload to the facility's EMR for other staff caring for the resident to have access. An interview with the AP (and medical director) on 7/29/24 at 9:54 AM revealed that he and his NP do not document directly in the facility's EMR. They document in his EMR that he uses in his office. He reported that the NP should be printing his notes and bringing them to the facility each Wednesday. This process does not follow the regulatory requirements. During an interview with medical record (MR) Staff #4 on 7/30/24 at 9:43 AM she reported that she had access to the AP and NP notes written in his office EMR. She was not informed of each visit in order to know when to access the notes to upload them to the facility's EMR. She reported that the current NP either faxes or drops off their notes each Wednesday when they come in. However, they were not bringing the AP's notes. These concerns were reviewed with the Director of Nursing and the Regional Director of Clinical Operations (RDCO) on 8/5/24 at 10:29 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 40927 Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that physicians visits were conducted every 30 days for the first 90 days and at least every 120 days after, and the nurse practitioner (NP) visiting in between to ensure the resident had a visit every 60 days. This was evident for 2 (Residents #9 and #914) of 6 residents reviewed for quality of care. The findings include: On 8/1/24 at 10:56 AM, a review of the facility's policy titled Physician Visits revealed there was no date when the policy was written or implemented. The policy read in #3 that NPs may visit the resident after the initial physician visit and #4 read that NPs may alternate with the physician during the first 90 days of admission, which does not align with the regulatory requirement that the physician must visit the resident every 30 days for the first 90 days. The policy failed to mention the method in which the facility would track these visits to ensure they were done. At the bottom of the policy, it was noted under references the previous regulatory tag #s F387 and F388 versus the current tags. 1) On 7/23/24 at 9:47 AM, a review of Resident's #9's paper record revealed a history and physical conducted on 4/21/22. An electronic medical record (EMR) review for Resident #9 on 7/31/24 at 9:58 AM revealed that the resident had 3 physician visit notes uploaded in the record, dated 6/17/22, 8/4/22, and 7/19/24. A review on 7/31/24 at 9:49 AM with the medical record (MR) (Staff #4) revealed that additional visits were conducted by the physician but were not present in the medical record. Review of these revealed the attending physician failed to visit the resident in 5/2022 (the 2nd month after admission) and failed to conduct a visit every 120 days in 2023 and 2024. The attending physician was interviewed on 7/29/24 at 9:54 AM. He reported that his notes were written in his office electronic medical records and the nurse practitioner would print them and bring them in every Wednesday. During this interview, he reported that the last time he visited Resident #9 was on 7/29/24 when s/he was readmitted to the facility.After the surveyor and medical director reviewed the notes available in the medical record, the medical director stated that he was behind on visits. 2) A review of the electronic medical record (EMR) for Resident #914 on 7/26/24 at 10:26 AM revealed in the miscellaneous tab that three physician notes had been uploaded for 4/5/23, 8/23/24, and 12/22/23 all titled as history and physical visits. The resident was admitted in 4/2023 and should have been seen by the physician in 4/2023, 5/2023, and 6/2023 for the first 90 days, however, the physician failed to conduct the 3rd visit in 6/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review on 7/31/24 at 9:49 AM with the medical record (MR) (Staff #4) revealed that additional visits were conducted by the physician and the NP, but were not present in the medical record. A review of the NP and physician notes revealed the resident was not visited in 6/2023 nor every 60 days, as there was no visit for 2/2024, and 4/2024. An interview with the attending physician on 7/29/24 at 9:54 AM revealed he comes to the facility at least 2 times a week and maybe more depending on admissions. He stated that he was behind on resident visits. During an interview with medical record (MR) (Staff #4) on 7/30/24 at 9:43 AM she reported that the Assistant Director of Nursing (ADON) let the physicians and NP know when visits were due. The ADON was interviewed on 7/30/24 at 9:56 AM regarding the process for ensuring residents had timely visits by the physician and NP. She reported that she does not manage the physician and NP visits for the residents. When asked if she was aware of the timeframes for each visit, she reported that she was not. An interview on 8/2/24 at 8:35 AM with the Director of Nursing (DON) and Medical Record (MR) #4 revealed that the Assistant Director of Nursing (ADON) was responsible for ensuring the timeliness of the physician and nurse practitioner notes. However, on 8/5/24 at 10:29 AM while reviewing the concerns with the Regional Director of Clinical Operations (RDCO) and the DON, the RDCO reported they had addressed this concern with the attending physician (and Medical Director) by showing him how to look up the physician visits in the Point Click Care (electronic medical record). It was unclear which process the facility was to follow to ensure the residents were seen in a timely manner. The concerns were reviewed with the Administrator on 8/5/24 at 11:05 AM. Cross Reference: F710 and F711

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 30428 Based on review of the medical record and interview with facility staff, it was determined that the facility failed to implement appropriate interventions for a resident with identified elopement potential on a resident with documented altered mental status. This was identified during the review of 1 of 6 residents (#922) reviewed for elopement. The findings include: Review of the facility reported incident on 7/25/24 reported on 5/2/23 an incident where Resident #922 was found outside the facility by the previous Director of Nursing (DON). According to the report, the resident was not known to the DON, she just found an individual on his/her knees outside the facility when she arrived to work on 5/2/23 at 7:29 AM. The nurse and the DON escorted the individual into the facility for an assessment and determined at that time that s/he was the missing resident identified as Resident #922. Resident #922 identified him/herself and stated that s/he was going home to pay my bills and see my dog. According to the facility investigation's initial and 5-day report, an elopement assessment is completed on admission. Anytime a resident scores 10 or higher, that must be discussed with the supervisor for appropriate interventions. Resident #922 was documented on the hospital discharge summary as having intermittent confusion, lacking capacity after being seen by psychiatry and requiring a 1-1 sitter for a time being related to behaviors of confusion and combativeness, although no interventions related to this was implemented at the time of the resident's discharge to the facility. Review on 7/25/24 at 8:42 AM revealed that a nursing admission assessment was completed for Resident #922. This noted that s/he was alert to person and place and verbally appropriate. Resident #922 was documented for all aspects of mobility as 'did not occur,' though s/he was independently mobile with a cane. Record review also revealed that Resident #922 had an elopement assessment completed on 5/1/23 with a resultant score of 15. There was no documentation or noted review with any supervisor regarding this acquired score. There was also no care plans or other interventions put in place regarding these findings in the elopement assessment. These concern were reviewed with the current DON on 7/25/24 at 9:29 AM. She stated that, at the time of the incident, the DON/Unit manager and the nurse admitting residents should be reviewing the hospital discharge of residents so they know the discharge history which would have included his/her ability to be mobile and behaviors that had required a 1-1 sitter. Cross reference F610, F656

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 37276 Based on review on record review of facility documentation and staff interview, it was determined that the facility staff failed to conduct and document a comprehensive facility-wide assessment as evidence by failing to address: 1) the facility's average number of residents, 2) staff competencies necessary to provide the level and types of care needed for the resident population, 3) an evaluation of the facility's training program to ensure that any training needs are met for all new and existing staff, and contractual individuals providing services and volunteers, consistent with their expected roles and 4) Failed to have a facility-based and community-based risk assessment, utilizing an all hazards approach. This was evidenced during a Sufficient and Competent Nurse Staffing review, and extended survey review. This deficient practice has the ability to affect all residents in the facility. The findings include: The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require during both day-to-day operations and emergencies. The assessment is used to make decisions about the direct care staff needs as well as the facility's capabilities to provide services to the residents in the facility. The assessment must be reviewed as necessary and at least annually. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully. On 8/2/24 at 9:00 AM, a review of the facility assessment, a 25-page document labeled with the facility's name and Facility Assessment 2024 identified concerns. 1) In the resident profile section, Part 1, Section 1A, Facility Capacity and Physical Characteristics revealed documentation that the total number of beds licensed by the facility was 80 but failed to include the number of residents. The facility assessment had the description, Average Daily Census (past 3 months) with no response documented to indicate the facility's average daily census. 2) Section 1.E Acuity: Special Treatments and Resident Care Need, identified an average of 60 residents a month that had behavioral health care needs, and an average of 60 residents a month had a mental illness diagnosis, and an average of 15 residents a month had a dementia and/or Alzheimer's diagnosis. 3) Part 3: Facility Resources Need to Provide Competent Support and Care of our Resident Population Every Day and During Emergencies documented: Section 3.B Staffing Plan: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- the facility will have sufficient staff with competence and skills aligned to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident as determined by individual plans of care, census, acuity and diagnosis of facilities population, and - the facility has Psychogeriatric Services (Behavioral Health practitioners) that have competencies and skill sets to care for many behavioral diagnoses. These clinicians have appropriate training and supervision in caring for residents with mental and psychosocial disorders. Section 3.C Individual staff assignment: The facility considers areas such as, but not exclusively limited to the following: Resident care needs, acuity, census, being cared for by a specific gender, language and communication abilities. Section 3.D Staff training education and competencies Licensed nurses: Certification required: valid Nursing license; Competency requirements: See Licensed Nurse Competency Direct care Certification requirements: Valid GNA or CMA certification: Competency requirements: See GNA/CMA competency checklist Continued review of the facility assessment failed to reveal evidence that the facility identified and recommended staff training and competencies. During the recertification survey, review of employee files and staff training revealed that the facility had no system in place to provide staff the required training and competencies and record the hours and type of annual inservice training completed by each staff member to accurately evaluate and ensure competency of staff. In addition, the facility failed to include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Review of 5 randomly selected employees reviewed for continuing education and competencies revealed: 2 of 5 GNA staff members had not received abuse training. 5 of 5 GNA staff members had not received at least 12 hours of continuing education in the past year. 5 of 5 GNA staff members had not received an annual performance review. 5 of 5 GNA staff members had not received behavior management training. 5 of 5 GNA staff members had not received communications training. 4 of 5 GNA staff members had not received infection control and prevention training (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) Review of the facility assessment failed to reveal a facility-based and community-based risk assessment , utilizing an all-hazards approach had been included in the facility assessment. On 8/1/24 at 4:00 PM, the above concerns were discussed with the Director of Nurses (DON) and Staff #16, Regional Director for Clinical Operations. The DON and Staff #16 acknowledged the concerns, and no further comments were offered at that time. On 4:10 PM, the DON reported to the surveyor the Nursing Home Administrator was made aware of the concerns with the facility assessment. Cross Reference: F941, F943, F945, F947, F949F