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	02/21/2025

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. 31145 Based on observation and medical record review, it was determined that facility staff failed to develop a comprehensive, resident centered care plan for a resident with a prosthetic eye. This was evident for 1 (#3) of 3 residents reviewed during a complaint survey. 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. On 2/21/25 at 8:45 AM a review of Resident #3's medical record revealed that Resident #3 was admitted to the facility in July 2023 with diagnoses that included late onset Alzheimer's disease, neurocognitive disorder with Lewy Bodies, and age-related physical debility. Resident #3 also had a prosthetic left eye since the age of 4. Review of January 2025 physician's orders revealed Resident #3 had a prosthetic left eye which required daily cleaning. The left eye was to be removed from the socket, cleansed with NSS (normal saline solution), patted dry with dry paper towel, and replaced back in the eye socket. Review of Resident #3's care plans failed to have a care plan specifically for the cleaning of the prosthetic left eye and how to manage attempting to remove and replace the eye when Resident #3 exhibited behaviors related to Alzheimer's disease and Lewy Body Dementia. A care plan, the resident has a behavior problem r/t not keeping prosthetic eye in place. Resident refuses to keep it in place was initiated on 2/20/25, however the resident has been at the facility since July 2023 and a resident centered care plan had not been in place related to the prosthetic eye. The care plan documented, Anticipate and meet the resident's needs, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. The care plan was not resident centered specific to Resident #3 and did not have approaches specific to Resident #3. On 2/21/25 at 2:00 PM the care plan was reviewed with the Director of Nursing who confirmed the findings.

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

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31145 Based on medical record review and interview, it was determined the facility failed to renew cleaning of a resident's prosthetic eye after the resident returned from the hospital on multiple occasions. This was evident for 1 (#3) of 3 residents reviewed during a complaint survey. The findings include: On 2/21/25 at 8:45 AM a review of Resident #3's medical record revealed the resident was admitted to the facility in July 2023 with diagnoses that included, but were not limited to, Alzheimer's disease with late onset, neurocognitive disorder with Lewy Bodies, dementia, and age-related physical debility. Review of the history of Resident #3 revealed Resident #3 had a left prosthetic eye since the age of 4 years old. Review of Resident #3's physician's orders revealed an order that was written on 1/16/25 that documented, left glass eye (prosthetic) qd (every day) cleaning. Remove left eye from socket, cleanse eye with NSS (normal saline solution), pat dry with dry paper towel, replace in eye socket. Further review of the medical record revealed the resident had the order to clean the prosthetic eye when the resident was first admitted to the facility in July 2023, and it was on the July 2023 and August 2023 Treatment Administration (TAR) record. On 2/11/25 at 11:26 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she had been a nurse at the facility for the past two and a half years. She stated she was Resident #3's nurse when he/she was first admitted to the facility. The ADON stated when the resident was first admitted the spouse stated that the resident would personally take care of the prosthetic eye, but over the course of his/her stay and the dementia, the resident was unable to do for him/herself. The ADON was asked why the order was just now written on January 16, 2025 and placed on the January 2025 TAR. The ADON stated that she had been doing chart audits and noticed that the order for the glass eye was not on the TAR. She stated the original order was to clean everyday and that is what the spouse said was the normal routine. When the resident was first admitted that was the recommendation for us. The order was discontinued when the resident was sent out to the hospital and with him/her coming and going it was one order that never got placed back into the treatments. The ADON stated that the staff used to remove the eye and then replace it. The ADON stated her position changed to ADON from charge nurse; therefore no one ever came to her asking about the order and the spouse never said anything to her. The ADON stated she knew it was a prior order, and that order was never discontinued by the physician, so she put that order back in as it was prior to now. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON was asked if the physician was notified that the order had not been on the treatment record. The ADON stated no, that she just put the order back on the TAR. The ADON was asked if she had informed the spouse that the order was placed back on the TAR. She stated that the spouse was called the evening that the resident refused to allow anyone to put the eye back in, as the spouse could usually convince the resident to allow staff to do that, however there was no documentation of that phone call. On 2/21/25 at 5:30 PM the concern of the treatment to the prosthetic eye was discussed with the Director of Nursing and the Nursing Home Administrator.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 31145 Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to hold a medication when outside of physician ordered parameters and failure to notify the physician when the blood pressure was outside of physician ordered parameters. This was evident for 1 (#3) of 3 residents reviewed during a complaint survey. The findings include: On 2/21/25 at 8:45 AM a review of Resident #3's medical record was conducted and revealed Resident #3 had hypertension and was taking Lisinopril 40 mg. every day and Clonidine 0.1 mg. 2 times a day to treat the hypertension. Review of a physician's order for Clonidine 0.1 mg, documented to hold for systolic greater than 150. Systolic blood pressure, the amount of pressure in the arteries during the contraction of the heart muscle, is the top number of the blood pressure reading. Review of the January 2025 Medication Administration Record (MAR) documented on 1/18/25 at 9:00 AM and 8:00 PM the blood pressure was 155/63. The medication was administered both times. On 1/21/25 at 9:00 AM the blood pressure was 176/80, on 1/22/25 at 9:00 AM the blood pressure was 156/61, and on 1/27/25 at 9:00 AM the blood pressure was 164/74. The medication was administered on those dates when the systolic blood pressure was outside of physician ordered parameters. Further review of the January 2025 MAR documented the order, blood pressure every shift. Call MD if SBP (systolic blood pressure) was greater than 160. On 1/16/25 day shift the blood pressure was 168/73 and on 1/21/25 evening shift the blood pressure was 176/80. There was no notification to the physician found in the medical record. Review of the February 2025 MAR documented that the systolic blood pressure was above 160 on the following days with no physician notification documented in the medical record: Day shift: 2/7: 161/72, 2/9: 189/85, 2/11: 168/88, 2/12: 170/84, 2/14: 164/72 Evening shift: 2/6: 164/72, 2/9: 175/88, 2/10: 168/88, 2/11: 168/88 Night shift: 2/11: 162/92 On 2/21/25 at 1:55 PM the medications and the MAR were reviewed with the DON. The DON confirmed the errors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation and staff interviews it was determined that the facility failed to follow infection control practices and guidelines by failing to notify the local health department of a gastrointestinal outbreak and failed to post a sign in the facility and at the entrance to inform staff and visitors of the outbreak. This was evident for 1 day of a complaint survey. The findings include: On 2/21/25 at 8:30 AM a tour of the facility was conducted. While walking down the 400 hallway observation was made of several rooms with contact isolation signs on the door with PPE (personal protective equipment) outside of the door. PPE consists of gowns, masks, and gloves. Observation was made in room [ROOM NUMBER] of a resident with 4 cups on the over the bed tray table and a basin in the resident's lap. The surveyor asked the resident how he/she was and the resident stated he/she was nauseated, the reason for the basin. On 2/21/25 at 11:26 AM an interview was conducted with the Assistant Director of Nursing (ADON), who was also the Infection Preventionist. She stated that the past 24 hours that some residents had nausea, vomiting, diarrhea, coughing, and congestion.She stated that it appeared to be a 24 to 48 hour GI bug. She stated approximately 24 residents were not feeling well. The ADON was asked if she had notified the local health department. She said she had not. She stated that she reached out to the regional nurse, Director of Nursing, and the Nursing Home Administrator. The ADON stated she was in the midst of going around making sure signage was up and that PPE was available for each room with a sick resident. The ADON stated that contact precautions were in place with contact isolation signs up on the doors and PPE outside of the doors and that extra cleaning was being done. The ADON was informed that it was a requirement to notify the local health department when more than 2 residents were affected as it was considered an outbreak. The ADON was also informed that there was no signage at the front door alerting residents and visitors of the outbreak.