

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2025
NAME OF PROVIDER OR SUPPLIER  Creekside Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, observations, and record review the facility failed to ensure alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made and not later than 24 hours to other officials (including to the State Survey Agency and Adult Protective Services in accordance with State law through established procedures for 4 of 10 residents reviewed for abuse (R#11, R#2, R#6, and R#19). Findings Include: Record review of the abuse policy titled, Abuse Prevention Program last revised on 11/30/2022 documented, the administrator was responsible for the overall coordination and implementation of the facility's abuse prevention program policies and procedures. The administrator had the authority to delegate, coordinate and implement various components of the abuse policies and procedures to other individuals within the facility. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origins and misappropriation of property will be reported by the facility administrator or her designee to the state agencies, within 2 hours of the alleged abuse if it resulted in injury and within twenty-four hours if the alleged abuse does not result in serious bodily injury.</p> <p>1. Record review of R11's face sheet (a Resident information data sheet) revealed R11's original admission was dated 4/8/2024 and R11 was discharged on 10/2/2025. Her diagnoses included Chronic Respiratory failure, Chronic Obstructive Pulmonary disease, Morbid Severe Obesity, and Chronic Kidney disease.</p> <p>Record review of the facility reported incident dated 9/16/2025 at 1:52 PM, to the State Surveying Agency. The facility documented that they notified the Resident Representative on 9/13/2025 at 3:30 PM and notified the police department (#25005124). The previous activities director (PAD) 32, documented on 9/13/2025 at approximately 1:30 PM, R18's family brought two of their granddaughters to play bingo. The granddaughters had an argument and started yelling using racial slurs. The situation got worse when one of the granddaughters started flipping tables and throwing bingo chips and chairs at the Residents. Staff were hit by bingo chips as they attempted to intervene and to free Residents to safe areas. R18's granddaughter eventually cooled off when the police arrived.</p> <p>Record review of R11's progress notes dated 9/13/2025 17:50 PM, revealed Licensed Practical Nurse (LPN) 33 documented, sometime in the afternoon an incident happened in the dining room. R11 was hit with poker chips and a plastic vase. R11 was upset. R11's family stated they were going to press charges. R11's family stated that no one called when it happened. The family was at the facility before LPN 33 found out something had happened. LPN 33 did an assessment and found no marks of any kind.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 215113	If continuation sheet Page 1 of 12

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of R11's quarterly, Minimum Data Set assessment (MDS) dated [DATE] documented in section GG of the MDS that R11 used a wheelchair for ambulation and required supervision and assistance. His/Her BIMS score was not addressed.</p> <p>An interview on 10/16 2025 at 10:05 with House Keeping (HK) HK 35 revealed that on 9/13/2025 at approximately 1:30 PM, he was on the floor working when he heard staff yelling for help. He explained there were ten Residents during the bingo session which took place in the dining room. HK 35 stated he observed R11 screaming, and he observed a young girl approximately sixteen years old throwing bingo chips, chairs and flipping tables at the Residents and staff. At approximately 2:00 PM nursing staff started taking the residents out of the dining room area. According to HK 35, R26, R19 and R11 had injuries. R26 got a bruise on the leg and R19 was hit in the face.</p> <p>During an interview on 10/16/2025 at 10:39 AM, the Assistant Director of Nursing (ADON) ADON 2, stated she was not involved in the abuse investigation which occurred on Saturday 9/13/2025, during a bingo session. She explained the facility was required to report all abuse within 2 hours and within 24 hours where there was no injury to the State surveying agency.</p> <p>During an interview with the Nursing Home Administrator (NHA), NHA 3 on 10/17/2025 at 8:30 AM, she stated the abuse, incident which occurred on 9/13/2025 during a bingo session, was not reported in a timely manner and explained, staff took too long to sort out the different reporting agencies that were involved including law enforcement and concluded the abuse should have been reported in a timely manner.</p> <p>The facility policy titled Abuse Prevention Program last revised December 2016, read in part the residents had the right to be free from abuse and involuntary seclusion. The policy further stated that the facility was to identify and assess all possible incidents of abuse, investigate and report any allegations of abuse within timeframes as required by federal requirements.</p> <p>2. Resident #6 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, delusional disorder, general anxiety disorder, and dementia.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #6 had severe cognitive impairment with continuous inattention and disorganized thinking. Resident #6 was coded for hallucinations, delusions, physical behaviors directed towards others (such as hitting, kicking, pushing, scratching, and grabbing), other behavioral symptoms not directed towards (such as verbal symptoms of screaming or disruptive sounds, pacing, and rummaging), and wandering. Resident #6 was coded as independent for mobility.</p> <p>The care plan, which was last reviewed on 8/11/25, revealed Resident #6 was an elopement risk/wanderer and impaired safety with interventions to distract the resident from wandering which included: offer pleasant diversions, structured activity, and conversation. Resident #6 had a care plan for behavior problems related to refusal of medication, invading personal space, and yelling at staff with interventions which included one to one (1:1) supervision at all times and provide opportunity for positive interaction and attention.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's abuse investigation revealed that on 7/05/25 (no time noted) Resident #6 was reported to have been locked in the conference room with two Geriatric Nurse Aides (GNAs) and was blocked from exiting. Further review of the investigation revealed that the Administrator was not notified of the allegation of abuse until 7/08/25 at 5:10 pm.</p> <p>The Facility Reported Incident Initial Report Form dated 7/08/25 revealed the facility became aware of the allegation of abuse on 7/08/25 at 4:00 pm when the Unit Manager was notified of the incident that occurred on 7/05/25. The date and time the Administrator was notified was documented as 7/08/25 at 5:10 pm and the initial report was submitted to the state agency by the Assistant Director of Nursing (ADON) on 7/08/25 at 6:00 pm.</p> <p>A telephone interview was conducted with GNA #18 on 10/14/25 at 1:35 pm who revealed she notified Nurse #23 immediately after she saw Resident #6 was blocked in the conference room with the two GNAs. GNA #18 stated the incident occurred on 7/05/25 around the lunch hour.</p> <p>During a telephone interview with Nurse #23 on 10/16/25 at 10:22 am she revealed she recalled GNA #18 reported the incident to her while she was administering medications down the hall. Nurse #23 stated she did not witness the incident and she did not speak to the two GNAs reported to have blocked Resident #6 in the conference room. Nurse #23 stated she did not recall GNA #18 report that the door was locked just that the door was closed. Nurse #23 stated she should have reported the abuse allegation on 7/05/25 but with her workload and job activities, she may have forgotten to notify someone about the abuse allegation.</p> <p>A telephone interview was conducted on 10/17/25 at 8:00 am with the Assistant Director of Nursing (ADON) who revealed she was responsible to conduct the investigation for abuse allegations at the facility. She stated she was notified of the incident on 7/08/25 at 4:00 pm by the Unit Manager and she notified the Administrator. The ADON stated that all staff were educated on the proper timeframe of reporting abuse allegations and the abuse allegation for Resident #6 should have been reported to either her, the Director of Nursing (DON), or the Administrator immediately.</p> <p>An interview was conducted with the DON on 10/14/25 at 2:01 pm who revealed she recalled being notified of the incident when she returned to work from the weekend. The DON stated Nurse #23 should have called the ADON to report the abuse allegation when it was reported to her by GNA #18 on 7/05/25.</p> <p>A telephone interview with the Administrator was conducted on 10/17/25 at 10:48 am who revealed she was on vacation at the time the incident with Resident #6 occurred but she was notified by the facility on 7/08/25. The Administrator stated Nurse #23 should have reported the abuse allegation to the DON or ADON at the time the abuse allegation was reported to her.</p> <p>3. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbances, Parkinson's disease, and delusional disorder.</p> <p>The Minimum Data Set (MDS) quarterly assessment, dated 7/27/25, revealed Resident #2 had moderate cognitive impairment, unclear speech, and Resident #2 was not coded for behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R #2 had a care plan that was last reviewed on 6/18/25 for disturbed thought processes related to perceptual and cognitive distortions, exacerbated by choice of tv show selections as demonstrated by disruptions in thought and accusations involving rape and assault. The care plan had interventions which included avoid challenging the content of resident behaviors, offer a change in tv show, and provide honest and consistent feedback in a nonthreatening manner.</p> <p>Review of the Employee Witness Statement completed by the Unit Manager revealed Geriatric Nurse Aide (GNA) #21 reported an allegation of abuse for Resident #2 on 9/10/25 during the evening (no specific time noted). The statement further noted that the Unit Manager had requested GNA #21 to write a statement and as of 9:00 pm no reports were received by the Unit Manger. The Employee Witness Statement also noted that on 9/11/25 the Assistant Director of Nursing (ADON) was notified of the allegation of abuse. The Employee Witness Statement was signed by the Unit Manager.</p> <p>Review of the facility's abuse investigation revealed that on 9/10/25 during the evening shift (no time noted) GNA #21 reported to the Unit Manager that GNA #22 was reportedly rough while providing care to Resident #2 which including pulling the resident's arms and taking the resident hands and banging them against his/her chest. Further review of the investigation revealed the Administrator was not notified of the allegation of abuse until 9/11/25 at 4:30 pm.</p> <p>The Facility Reported Incident Initial Report Form dated 9/11/25 revealed the facility became aware of the allegation of abuse on 9/10/25 during the evening shift. The date and time the Administrator was notified was documented as 9/11/25 at 4:30 pm and the initial report was submitted to the state agency by the Assistant Director of Nursing (ADON) on 9/11/25 at 6:30 pm.</p> <p>A telephone interview was conducted with GNA #21 on 10/17/25 at 11:30 am who revealed she reported the allegation of abuse of Resident #2 to the Unit Manager on 9/10/25 sometime before the dinner meal.</p> <p>An attempt to conduct a telephone interview with the Unit Manager on 10/17/25 was unsuccessful.</p> <p>During a telephone interview on 10/17/25 at 7:59 am with the ADON, she revealed she was responsible for the investigation of abuse allegations at the facility. She stated she was notified on 9/11/25 of the allegation of abuse for Resident #2 and she would have told the Administrator immediately. The ADON stated that all staff were educated on the proper timeframe of reporting abuse allegations and she stated the abuse allegation should have been reported to either her, the Director of Nursing (DON), or the Administrator immediately.</p> <p>A telephone interview was conducted on 10/17/25 at 12:00 pm with the DON who revealed the Unit Manager was responsible to notify the Administrator, ADON, or her of any abuse allegation when it was reported.</p> <p>The Administrator was interviewed on 10/17/25 at 10:51 am who revealed she was the Abuse Coordinator for the facility and that the ADON was the staff member that was responsible to submit the reports to state agencies and conduct the investigation. She stated the facility was responsible to report the abuse allegation to the state agency within two hours of notification. The Administrator stated the Unit Manager was responsible to report the allegation of abuse for Resident #2 immediately.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy titled Abuse Prevention Program last revised December 2016, read in part the residents had the right to be free from abuse and involuntary seclusion. The policy further stated that the facility was to identify and assess all possible incidents of abuse, investigate and report any allegations of abuse within timeframes as required by federal requirements.</p> <p>4. Resident #19 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, Anxiety disorder, Chronic obstructive pulmonary disease, Major depressive disorder, Hypertension and Osteoarthritis.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #19 had severe cognitive impairment.</p> <p>Review of the facility's abuse investigation revealed that on 9/13/25, at 2:44 pm, the Administrator was made aware of a juvenile visitor was in the dining room during bingo and become angry and started throwing objects and turning over tables. Resident #19 was in the activities room and was hit by one of the objects thrown. Resident #19 did not sustain any injuries from the object. Further review of the investigation revealed the state agency was not notified of the allegation of abuse until 9/16/25 at 1:51 pm.</p> <p>The Facility Reported Incident Initial Report Form dated 9/13/25 revealed the facility became aware of the allegation of abuse on 9/13/25 at 2:30 pm and the Administrator was notified on 9/13/25 at 2:43 pm of the incident that occurred on 9/13/25 at 2:30 pm. The date and time the Administrator was notified was documented as 9/13/25 at 2:43 pm and the initial report was submitted to the state agency by the Director of Nursing on 9/16/25 at 1:51 pm.</p> <p>The Administrator was interviewed on 10/17/25 at 10:51 am who revealed she was the Abuse Coordinator for the facility. She stated the facility was responsible to report the abuse allegation to the state agency within two hours of notification. The Administrator stated the facility was responsible to report the allegation of abuse for Resident #19 immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interviews the facility failed to maintain documentation that an abuse allegation was thoroughly investigated. This deficient practice was identified for 1 of 10 residents reviewed for abuse (Resident #2). The findings included: The facility policy titled Abuse Prevention Program; Policies, Procedures, &amp; Information last reviewed on 11/30/22, revealed that witness reports will be obtained in writing, either the witness will write their statement and sign and date, or the investigator may obtain the stated and read it back to the member and have them sign it. The policy further stated that upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbances, Parkinson's disease, and delusional disorder. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment, unclear speech, and Resident #2 was not coded for behaviors. R #2 had a care plan last reviewed on 6/18/25 for disturbed thought processes related to perceptual and cognitive distortions, exacerbated by choice of tv show selections as demonstrated by disruptions in thought and accusations involving rape and assault. The care plan had interventions which included avoid challenging the content of resident behaviors, offer a change in tv show, and provide honest and consistent feedback in a nonthreatening manner. Review of the facility's abuse investigation provided by the Administrator revealed that on 9/10/25, during the evening shift, GNA #21 reported to the Unit Manager that GNA #22 was reportedly rough while providing care to Resident #2 which included pulling the resident's arms and taking the resident hands and banging them against his/her chest. The facility investigation revealed the facility verified the allegation of abuse by one credible witness who provided a statement. The facility's investigation documentation provided by the Administrator for review contained the facility reported incident forms, one witness statement that was written by the Unit Manager with the information that was reported to her by GNA #21, email correspondence between the Assistant Director of Nursing (ADON) and the staffing agency for GNA #21 and GNA #22, and one hand written statement with questions and answers noted. The hand written statement was not dated, it had no name of the person giving the statement, and no name or signature of the person writing the statement (later identified as Resident #2's statement). The investigation documentation had no written or signed statement from GNA #21, who reported the abuse allegation, and there were no written statements from other staff that were present and provided care to Resident #2 during the shift of the abuse allegation. During a telephone interview on 10/17/25 at 8:00 am and a follow-up interview at 12: 20 pm with the Assistant Director of Nursing she revealed she was responsible for the abuse investigations at the facility. She stated she would normally attempt to obtain interviews from the staff involved but at times she was unable to get all the statements if she was not present at the time of the abuse allegation. She stated she did recall several statements that she was able to obtain from staff members for Resident #2's abuse allegation but she would have to look for them. The ADON later reported she was unable to locate the statements from Resident #2's abuse allegation so she had begun to contact the staff today (10/17/25) to obtain their statements. The ADON stated she should have obtained all statements of the staff that were working at the time of the abuse allegation including the statement by the staff member that reported the allegation of abuse and provided all the information to the Administrator once the investigation was completed. A telephone interview was conducted with the Administrator on 10/17/25 at 10:48 am who revealed the ADON was responsible to complete the abuse investigations and submitted the required reports for the facility. The Administrator stated the ADON should have obtained statements from all staff that worked on the day of the abuse allegation and maintained those statements in the investigation file. The Administrator confirmed the facility had no further information regarding the abuse investigation other than what was previously provided.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review it was determined that the facility failed to 1.) provide sufficient supervision, prevent an avoidable accident, follow appropriate safety procedures and to utilize the use of two staff persons and 2) provide an appropriate mattress and bed to prevent a fall. This was evident for 2 residents (R10 and R23) of 4 residents reviewed who required a bariatric bed and mattress. The deficient practice resulted in harm to both R10 and R23. The facility implemented effective and thorough corrective measures following the incidents and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance.</p> <p>Findings Include:</p> <p>Record review of the facility undated policy titled Safe lifting and movement of Residents documented, the Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of Residents. Safe lifting and movement of Residents is part of an overall facility health and safety program, which involves employees identifying problem areas and implementing workplace safety and injury prevention strategies.</p> <p>1. Record review of R10's face sheet (a document containing Resident information and data) revealed R10's showed his/her original admission date was 05/28/2022. His/Her diagnoses included Cerebral Infarction, Chronic Systolic Congestive Heart failure with shortness of breath and presence of Heart Valve Replacement Cardiomegaly.</p> <p>Record review of R10's physician order, which was dated 4/7/2024, documented R10 required a bariatric pressure reducing mattress.</p> <p>Record review of R10's quarterly, Minimum Data Set assessment (MDS) dated [DATE], documented in section GG of the MDS that R10 was impaired on both sides of the upper extremities. R10 required maximum assistance with personal hygiene.</p> <p>Record review of R10's discharge/return anticipated, Minimum Data Set assessment (MDS) dated [DATE], documented in section GG of the MDS, R10 was dependent on staff with personal hygiene and required substantial maximum assistance from lying to sitting on the side of the bed.</p> <p>Record review of R10's significant change Minimum Data Set assessment (MDS) dated [DATE], revealed R10 had a BIMS score of 14, indicating R10 was cognitively intact.</p> <p>Record review of R10's progress Notes dated 08/19/2024 at 07:59 AM, revealed Registered Nurse (RN) 4 documented R10 had a witnessed fall in which they rolled out of bed during incontinent care. R10 slid and landed on his/her knees. R10 reported difficulty moving his/her lower extremities due to a pain level of 10 out of 10. R10's physician was made aware. The Physician gave orders to transfer R10 to the emergency department for evaluation and treatment. R10's Resident Representative was made aware of the incident and the hospital transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of R10's hospital Discharge summary dated [DATE] revealed that R10 was admitted on [DATE] and was discharged on 8/26/2024. The discharge summary documented R10 sustained closed fractures of both femurs and fractured his/her tibia and fibula on his/her left leg.</p> <p>Record review of R10's care plan, last revised on 9/20/2024, documented R10 was bed bound due to fractures to legs, and the care plan directed staff to provide in room activity. The care plan further documented R10 had a communication problem due to a hearing deficit on the left ear which was worse than the right ear and instructed staff to allow adequate time to respond, to repeat as necessary, not to rush R10, and to request clarification from R10 to ensure understanding. The care plan directed staff to face R10 when speaking and to make eye contact.</p> <p>Record review of the facility bed audit dated 9/20/2024 revealed the Central Supply Director (CSD), CSD 5, documented her audit results and wrote that R10's bariatric mattress was too big for the frame. CSD 5 further documented that R10 had a new bariatric bed in the past with the correct frame and correct bariatric mattress. CSD 5 further documented that at some point the bed stopped working and staff switched to a smaller bed frame. CSD 5 concluded she was not aware when the last bed audit took place.</p> <p>During an interview on 10/16/2025 at 10:39 AM, the Assistant Director of Nursing (ADON), ADON 2, revealed R10 had a fall while an aide was providing incontinent care. R10 rolled out of his/her bed. ADON 2 stated she did not complete an incident report and concluded she should have completed an incident report.</p> <p>During an interview on 10/16/2025 at 11:42 AM, the Admissions Director (AD), AD 6, revealed the facility had Residents who required bariatric beds. AD 6 explained that part of her job duties included visiting Residents at the hospital prior to admission to determine if the Resident would require a bariatric mattress and submit the Resident information to the admission team to prepare for the Residents arrival.</p> <p>During an interview on 10/16/2025 at 11:58 AM, CSD 5 stated she oversaw the Medical Records and Central Supply departments. She stated R10 fell out of bed, fractured his/her legs, and was sent to the hospital. Facility staff asked the Resident to roll over during care and R10 landed on the floor. CSD 5 stated it was not the R10's fault. CSD 5 further explained facility staff did not adjust R10's bed frame to fit the size of the bariatric mattress and concluded the mattress was too big for the frame.</p> <p>During an interview on 10/17/2025 at 8:41 AM, the Director of Nursing (DON), DON 1 stated R10 was a maximum assist which meant at least two staff should have been present while staff provided care and concluded it was the responsibility for all staff to make sure R10's mattress fit the bed frame correctly. DON 1 stated that the accident was avoidable.</p> <p>During an interview with the Nursing Home Administrator (NHA), NHA 3, on 10/17/2025 at 8:50 AM, NHA 3 revealed staff should have avoided the accident. She stated that the Medical Records department did service staff after the accident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2025
NAME OF PROVIDER OR SUPPLIER  Creekside Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/2025 at 9:45 AM, the former DON, RN 8, revealed a GNA from a temporal agency instructed R10 to roll over during care. R10 landed on the floor and sustained multiple fractures. The DON explained, R10's bedframe was too small for the size of the mattress. She stated R10 was a two person assist with transfers and explained for bed mobility one person was sufficient. RN 8 further explained the accident was avoidable and added that staff did not place the correct bed frame in place which caused R10 to roll over the unguarded mattress. RN 8 further explained that part of the challenges the facility faced at the time of her employment was low staffing levels. She concluded the facility was allowed to use a few agency staff, and the facility did not accommodate her staffing requests.</p> <p>2. Record review of R23's face sheet showed his/her original admission was dated 09/16/2024 with diagnoses that included chronic respiratory failure with hypoxia, hyperlipidemia, morbid obesity, and muscle weakness. R23's admission Minimum Data Set (MDS) dated [DATE] indicated R23's Brief Interview for Mental Status (BIMS) score was 15/15 which indicates the residents' cognition was intact. R23's functional limitation in range of motion had no impairment on the upper extremity and impairment on one side of the lower extremity. MDS revealed the residents required substantial/maximal assistance with toileting and personal hygiene, required substantial/maximal assistance with roll left and right, needed partial/moderate assistance with sit to lying, partial/moderate assistance with lying to sitting, partial/moderate assistance with sit to stand, substantial/maximal assistance with chair/bed to chair transfer.</p> <p>The care plan initiated 10/31/2024 documented the resident was at high risk for falls due to history of falls, activity intolerance, Shortness of Breath (SOB) with exertion and glaucoma. The care plan directed the staff to anticipate and meet the residents' needs and to be sure the residents' call light is within reach.</p> <p>Review of the Admit Notice dated 09/16/2024 revealed the residents' mattress requirements as requiring the bed extended and a slightly larger mattress. It documented that R23 was tall (6'0) and his/her weight was 290pounds(lbs.).</p> <p>Review of R23's weight revealed the following weights.</p> <p>09/16/2024-295lbs</p> <p>09/25/2024-298lbs</p> <p>10/07/2024-320lbs</p> <p>Record review of R23 nurse's note dated 01/04/2025 revealed that Licensed Practical Nurse (LPN)6 documented R23 was observed lying on the floor beside the bed on his/her back with both legs extended and bed mattress over him/her. Oxygen (O2) on at 2Litres(L)/Min. R23 complained of back pain. It documented LPN#6 was unable to move R23 from the floor. LPN#6 Called 911 to help get the resident off the floor. The resident was sent to the emergency room (ER) for further evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility report dated 01/04/2025 revealed that R23 reported that s/he turned over (in bed) and landed on the floor and his/her back hurts. LPN#6, the nurse overseeing resident care on 1/3/2025-1/4/2025 at 11pm-7am shift, reported that R23 was lying on the floor beside his/her bed on his/her back with both legs extended and his/her mattress over him/her. The resident was experiencing back pain. The report further documented R23 was not moved from his/her position. The vitals were taken, and neuro checks were performed. Medical Doctor (MD)10 was notified and gave orders to send R23 to the Emergency Department (ED) for evaluation and treatment. A call was placed to 911 and R23 was sent to the hospital's ED for evaluation and treatment. The report revealed that R23 had an X-ray performed at the hospital which showed acute mildly displaced fractures of the right transverse processes at L1, L2 and L3 vertebrae. The report further revealed at the hospital R23 was on a pain management regiment, had neurosurgery consult with no intervention from their end, the resident worked with Physical Therapist (PT)/Occupational Therapist (OT) who recommended skilled nursing facility placement, the pain was improved with time, and R23 was deemed stable for discharge from the hospital. The corrective action taken by the facility was that R23 was previously on a standard mattress with no previous falls from bed. The intervention added after the fall R23 was placed on a bariatric mattress upon return from hospital.</p> <p>Record review of the hospital Computed Tomography (CT) scan dated 01/04/2025 documented R23 had acute mildly displaced fractures of the right transverse processes at L1, L2 and L3 vertebrae. The vertebral body height is maintained. There is a chronic fracture of the left transverse process of L2. There is vacuum disc phenomenon with prominent anterior marginal osteophytes at multiple levels in the lumbar spine.</p> <p>Record review of the Hospital Discharge summary dated [DATE] revealed discharge diagnoses as follows:</p> <p>Acute chronic back pain secondary to</p> <p>Acute mildly displaced fractures right transverse processes L1, L2, and L3 due to fall</p> <p>During an Interview on 10/16/2025 at 11:06 AM, the admission Director (AD6) stated that during R23's admission in September 2024, she sent an email to CSD 5 and the Housekeeping Manager (HM38) indicating the type of mattress that was appropriate for R23. AD#6 reported that she recommended R23 to have a bariatric mattress because of the resident's weight and height which was about 290lbs.</p> <p>During an interview on 10/16/2025 at 11:14 AM, CSD5 stated that before a resident is admitted to the facility, she receives recommendations from AD6 for the type of bed and mattress that a resident requires. CSD5 added that she usually checks the supply room to confirm that the mattress and bed recommended was available. She reported that she did not recall if she was working on the day R23 was admitted to the facility in September 2024. CSD5 stated that the housekeeping department was responsible for setting up the bed and the mattress in the residents' rooms before they were admitted to the facility. She reported that before R23 was admitted to the facility in September 2024, AD6 emailed her and the Housekeeping Manager that the required mattress was a bariatric mattress. CSD5 stated she could not explain the reason the resident was using a regular mattress and bed when s/he fell on [DATE]. She added that the resident should have been on a bariatric mattress and bed because of his/her weight and height.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2025 at 11:21AM, the Housekeeping Manager stated that before R23's admission to the facility in September 2024, she received an email from AD6 that indicated R23 required a bariatric mattress. The Housekeeping Manager stated the resident should have been using a bariatric mattress and bed but not a regular mattress when s/he fell from bed to the floor in January 2025.</p> <p>During an interview on 10/17/2025 at 9:30 AM, LPN #7 stated she did not recall the fall incident because it happened in January 2025, but she recalled that the resident was wide and tall.</p> <p>During an interview on 10/17/2025 at 11:02 AM, the Director of Nursing (DON) stated that before a resident was admitted to the facility, the housekeeping department and central supply department were responsible for making sure they set up an appropriate mattress based on a resident's weight and height. The DON stated that at the time of Resident #23's fall in January of 2025, the resident was using a regular mattress instead of a bariatric mattress. She stated that to prevent a resident from falling off the bed again, AD6 will email the height and weight of a resident to CSD5 and HM38 so they can have a bariatric mattress and bed available upon admission. She further stated the supply department would keep a spreadsheet on what residents are on bariatric mattresses and beds upon admission.</p> <p>During an interview on 10/17/2024 at 11:30 AM, the Administrator stated R23 should have been using a bariatric mattress and bariatric bed to prevent a fall from happening in January 2025. She added that the facility had implemented a plan of action which included AD6 sending an email to CSD5 and HM38 so bariatric beds will be available upon admission of residents to the facility. The Administrator added that the supply department would keep a spreadsheet on what residents are on bariatric beds and they will keep a spreadsheet with admission and discharges.</p>		