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	12/23/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the resident and staff it was determined the facility staff failed to ensure the doors to the facility laundry room and the mechanical/boiler room were locked when unattended by staff, to prevent unauthorized access by residents and others. This was evident for 1 (Resident #1) of 1 resident reviewed for accident hazards during the complaint survey. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this complaint survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of [DATE].The findings include:The facility's investigation of Facility Reported Incident #2678525 was reviewed on [DATE] at 9:35 AM. The report revealed that on [DATE] at approximately 9:00 PM, Staff #1 a GNA (Geriatric Nursing Assistant) was unable to locate Resident #1 while preparing to assist him/her with evening care. After a preliminary attempt to locate the resident failed, the nursing supervisor was notified, and staff began a search of the facility. A written statement from Staff #2 a GNA, revealed that during the search at approximately 9:30 PM, She looked in the laundry room while calling out for the resident. She heard the resident respond from the mechanical/boiler room located behind the laundry room. Staff #2 opened the boiler room door and found Resident #1 sitting on the floor approximately 2 feet away from his/her wheelchair. Resident #1 was assessed by the nurse and found to have a skin tear/laceration on the left shin and a bruise on the left forearm and right elbow; s/he was otherwise unharmed. The resident could not recall how s/he got into the mechanical room and indicated that s/he was looking for his/her (deceased) spouse.Resident #1's medical record was reviewed on [DATE] at 9:45 AM. The record revealed that Resident #1 was [AGE] years old with diagnoses which included but were not limited to Adjustment Disorder with mixed anxiety and depressed mood, Cognitive Communication Deficit, Delusional Disorders and Alzheimer's Disease with late onset. Resident #1 utilized a wheelchair for mobility and used his/her legs to propel him/herself around the unit. Resident #1 had a Plan of Care developed on [DATE] for elopement risk/wandering/related to disorientation to place, history of attempts to leave the facility unattended and impaired safety.An elopement assessment completed on [DATE] revealed Resident #1's score was 12 indicating s/he was high risk for elopement. A BIMS (Brief Interview for Mental Status) is used to assess cognitive function. A score of 0-7 = severely impaired, 8-12 = moderately impaired and 13-15 = intact. The record revealed Resident #1's BIMS score on [DATE] was 4/15 = severely impaired. An interview was conducted with Resident #1 on [DATE] at 3:25 PM. The resident was pleasant, friendly and sociable. However, s/he could not recall the incident on [DATE] and indicated that his/her memory was not very good. When asked why s/he had a bandage on his/her left lower leg Resident #1 stated, I got a really bad scratch one day about a month ago when I was riding my motorcycle. The surveyor conducted an interview and observed the laundry and mechanical rooms with Staff #3, the Maintenance Director on [DATE] 9:32 AM. The two hallway doors to the laundry room (clean side and dirty side) automatically locked when shut and required a keypad code to unlock.A door to the mechanical/boiler room was located on the back wall inside the clean area of the laundry room. This door had a locking lever type handle. The door required a key to open it from the laundry room side. A push and turn button mechanism was located on the handle on the boiler room side of the door. The door was found to be locked during the observation. Staff #3 confirmed that the door did not automatically lock. Within the mechanical/boiler room was an outside exit door. This door could be exited without a key by pushing on the crash bar and required a key to enter the boiler room from outside. Staff #3 indicated that he was contacted on the evening of [DATE] and immediately came to the facility when notified of the above incident. He inspected the laundry room door locks at that time and found them to be in good working order, and the mechanical room was locked. He indicated that due to lack of evidence of a mechanical malfunction he concluded that staff must have propped the doors open. He indicated that he immediately provided on the spot verbal education to all staff working on the evening of [DATE], on not propping any doors open due to risk of residents wandering into unauthorized potentially dangerous areas.Staff #3 explained to the surveyor that the laundry room doors are weighted and will close if they are not held open. The locks engage automatically when the door closes. This was verified by the surveyor during the observation.Staff #3 added that after this incident he inspected the doors, the locks and hinges and could not find any malfunction but