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	02/06/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to notify the resident's physician of a significant change in condition and a decision to transfer the resident from the facility. This was evident for 1 (Resident #83) of 2 residents reviewed for neglect. The findings include:Resident #83 passed away in late 2025. On [DATE] at 7:39 AM, the details of complaint2729325 for Resident #83 were reviewed and revealed concerns with coordination and notifying the physician to send the resident out during a change in condition.A review of Resident #83's medical records was conducted on [DATE] at 2:26 PM. The review revealed progress notes dated [DATE] that indicated the resident's code status was updated from full code to Do not resuscitate and [DATE] that indicated emergency medical services (EMS) arrived in the facility to pronounce that the resident had passed away.A Full Code means a patient wants all possible life-saving measures, including cardiopulmonary resuscitation (CPR), chest compressions, defibrillation, and intubation, if their heart stops or they stop breathingA Do Not Resuscitate (DNR) order is a legally binding medical directive instructing healthcare providers not to perform CPR if a patient's heart stops or they stop breathing. It is a proactive decision, often in conjunction with terminal illness or advanced age, designed to allow natural death, sometimes referred to as no code or Allow Natural Death. The Director of Nursing (DON) was interviewed on [DATE] at 11:33 AM. During the interview, she reported her expectations from nursing staff when a resident is experiencing a change or decline in health status. After resident assessment, the physician should be notified immediately to determine the next steps and coordinate if EMS should be called. If the physician decides to send the resident to the hospital, an order is placed in the resident's medical order to reflect that decision. The DON further explained that all actions taken by the nurse in such events are expected to be documented in the resident's medical record as a progress note and/or change in condition evaluation.Also, during the interview, Resident #83's medical record was reviewed with the DON. The DON confirmed that EMS was called into the facility on [DATE]. However, she could not tell who or which staff called the EMS and stated, the nurse should have documented that. I would expect a change in condition (to show what the nurse did and that the physician was notified), but there is none in there. The DON also reported that there was no medical order to send the resident out to the hospital on [DATE] and explained that the nurse should have done a late entry (for progress notes and medical orders) if s/he was in a chaotic situation.The concern was discussed with the DON that there was no documentation to indicate that the nursing staff had notified Resident #83's physician of his/her change in condition or decision to transfer to the hospital. The DON verbalized understanding and acknowledged the concern.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, it was determined that the facility failed to report an alleged violation involving abuse. This was evident for 1 (R#88) of 1 residents reviewed during the annual recertification survey. The findings include: On 02/03/2026 at 9:22 AM, Intake #2697168 dated 12/19/2025 was reviewed for R#88. The intake was a complaint filed with OHCQ by Adult Protective Services on behalf of the resident's family. It was determined that R#88 was no longer at the facility and had discharged on 01/09/2026. On 02/03/2026 at 9:35 AM, the summary included with intake described R#88's family reporting visiting R#88 at the facility to often find him in a saturated and wet brief or soiled.On 02/03/2026 at 10:10 AM, the facility's grievance logs were reviewed for the previous 12 months, and it was revealed that on 12/08/2025, Staff #8 documented R#88's family reported the resident was left sitting in a very wet brief. The documentation indicated staff delayed care due to the residents' agitation. The record showed internal review and referral to psychiatric services. There was no evidence that this allegation of neglect was reported to OHCQ.Further review of grievance documentation revealed a grievance dated 09/31/2025 in which a facility GNA was reported to have raised a fist toward a resident and stated, Don't tell me what to do. I know how to do my job. There was no evidence this allegation of staff mistreatment was reported to OHCQ.On 02/04/2026 at 3:09 PM, the Nursing Home Administrator stated that allegations of abuse and neglect are reportable. When asked why the above grievances were not reported as Facility Reported Incidents, the NHA was unable to provide a rationale and confirmed to the surveyor that the policy that was provided is the facility's use of a templated policy that is not facility-specific.On 02/06/2026 at 2:30 PM, no additional evidence was provided to the surveyor prior to the conclusion of the survey.

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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. Based on record reviews and interviews, it was determined that the facility failed to ensure showers were provided/offered as scheduled to dependent residents. This was evident for 1 (Resident #89) of 2 residents reviewed for neglect. The findings include:Resident #83 was admitted into the facility in mid-2025 with diagnoses that include muscle weakness, morbid obesity, chronic pain, and abnormalities of gait and mobility. On 2/5/26 at 7:39 AM, an allegation related to complaint2729325, that showers were not being provided to the resident as scheduled was reviewed.During an interview with the complainant on 2/5/26 at 1:33 PM, s/he reported that Resident #83 would go 11 days with staff not providing showers.A review of Resident #83's medical record was conducted on 2/5/26 at 1:40 PM. The review revealed a medical order for showers scheduled on day shift every Monday and Thursday. However, this order was discontinued on 9/2/25. No other order was found for showers and there was no documentation in the resident's administration record to indicate showers were being provided.On 2/6/26 at 8:40 AM, further review of Resident #83's medical record revealed a quarterly assessment was conducted with an assessment reference date of 9/18/25, where section GG indicated the resident needed substantial/maximal assistance (helper does MORE THAN HALH the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) to safely complete shower activity.Facility staff had reported that shower/skin sheets are filled out whenever a shower is provided for a resident. A review of the shower/skin sheets for September 2025 was conducted on 2/6/26 at 9:05 AM. The review revealed Resident #83 had 1 documented shower provided on 9/11/25 (Thursday) for evening shift. The Director of Nursing (DON) was interviewed on 2/6/26 at 10:02 AM. During the interview, the DON reported that residents do not need orders for showers. All residents are scheduled for showers 2x a week and the schedule is dictated by the resident's room number and bed. (According to Resident #83's information, showers would have been scheduled on day shift every Wednesday and Saturday.) She also reported that aside from the shower/skin sheets, nursing aides document showers/baths under their task documentation.The DON was asked to print a copy of the nursing aides task documentation in September 2025 for Resident #83. A review of the documentation was conducted on 2/6/26 at 10:30 AM. The review revealed shower was provided on 9/13/25 (Saturday) for day shift.In a subsequent interview with the DON on 2/6/26 at 11:08 AM, the findings were discussed that in September of 2025, Resident #83 received 1 scheduled shower and 1 unscheduled shower. No other documentation was found to indicate showers were provided or refused on the other days the resident was scheduled to receive them. The DON confirmed the finding and acknowledged the concern.