STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215336	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hagerstown Healthcare Center	750 Dual Highway 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, the facility failed to maintain an environment free from Resident-to-Resident sexual abuse. Specifically, Resident #34 (R#34) made unwanted sexual contact with Resident #13 (R#13) one time. The facility census was 111 and the sample size was 34.The findings include:During an observation on 7/17/25 at 11:00 a.m., R#13 entered the room while this surveyor was speaking to his/her roommate. He/she was pleasant and engaging, sharing how R#13 and his/her roommate were close friends and always look out for one another. R#13 was clean and well-groomed without signs of distress. During an observation on 7/18/25 at 9:00 a.m., R#13 had no notable adverse reactions or concerns when asked about the incident with R#34, and he/she agreed to speak about the incident without hesitation. Review of the facility's policy titled, Maryland Abuse, Neglect, and Misappropriation, and dated 10/01/2024 revealed, Scope: This policy is applicable to all adult living centers in the State of Maryland. Definitions: . Sexual Abuse: non-consensual sexual contact of any type with a resident. Policy: It is the policy of this facility to provide resident-centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents. In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. If the alleged violation is verified, appropriate corrective action will be taken by the facility. The facility will be alert for conspicuous activity that may indicate abuse activities. regardless of resident voicing such incidents. VI. Protection from Abuse. 2. When the alleged abuse involves a resident-to-resident altercation, the residents will be separated by the staff and the appropriate physical assessments will be completed on each resident. Record review of R#13's medical records revealed he/she was admitted on [DATE] with diagnoses including facial weakness following unspecified cerebrovascular disease, seizures, iron deficiency anemia, anxiety disorder, PTSD, major depressive disorder, mood disorder, hyperlipidemia, GERD, otitis media, muscle spasm, traumatic brain injury due to GSW and blunt force trauma. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, an indication of moderate cognitive impairment. Review of Resident #13's capacity assessment dated [DATE] and signed by the nurse practitioner, reveal the resident, has adequate decision-making capacity (including decisions about life-sustaining treatments). Record review of R#13's Care Plan initiated on 4/14/25 documented that he/she was involved in alleged incident of being inappropriately touched by another resident with a goal of remaining safe and emotionally intact without enduring any adverse effects from alleged incidents by the following interventions: hand held bell provided to resident for alerting staff of unauthorized visitors, consultations with psychiatry and behavioral health, staff performing frequent rounds, and at STOP sign placed on the door in attempt to prevent others from entering her room. Review of R#13's progress notes revealed an encounter by the provider dated 4/14/25 documenting, .assessed at bedside today for acute visit for altercation with another resident. This resident reported that another resident came to [R#13's] room to visit and while they were talking [R#34] started touching [R#13] on the legs and arms. [R#13's] states that [he/she] asked [R#34] to stop a couple of times but [R#34] was still doing it. [R#13] states that he/she knows [R#34] was not something serious but he/she did not want [R#34]to get used to it. That is the reason [R#13] reported it to the Nurse. [R#13] states he/she does not want [R#34] to come to his/her room anymore. Education was provided to report to staff if the other resident approach (sic) again. Review of R#13's progress notes revealed a note by social services dated 4/14/25 documenting a Post-Traumatic Stress Disorder (PTSD) assessment was performed, and R#13 triggered for PTSD. The note further documented, Resident shared that [he/she] has been abused in the past. SSA will continue to assist and monitor as indicated. Care plan updated. Review of R#13's progress notes revealed a note by the psychiatric nurse practitioner dated 4/14/25 documenting, .resident reports, [R#34] came into my room yesterday about 4 p.m. and [he/she] touched me. [R#34] said 'I'm gonna get some of that. [He/she]'s not getting none of this. I just can't defend myself like I used to.' Denies telling staff about incident; yet stated, 'I'm from the streets, I'm used to handling it myself, further explaining that he/she and the other resident are friends and had been hanging out and talking, but not like that. There was no injury, and R#13 explained feeling safe on the unit and in his/her room and does not think [R#34] will touch him/her again and shared he/she will avoid being near [R#34] when

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review it was determined that the facility failed to provide sufficient supervision to prevent an avoidable accident from occurring by not following appropriate safety procedures while using a Hoyer lift (a mechanical device used to transfer and to lift Residents). As a result, Resident (R#7) suffered a fall with harm (fractures to collarbone and femur). This was evident for 1 (R#7) of 34 residents reviewed during a complaint survey. Findings Include: Record review of the facility undated policy titled “Mechanical Lifts and Transfer” documented, it was the facility policy to “provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the Residents. Safety is a primary concern of our residents, staff and visitors. The use of mechanical lifts requires a competent and skilled user and requires the use of two (2) employees to perform the lift safely, for both residents and employees. The policy is to provide general guidance for the use of mechanical lifts, including manually operated Total Lifts, also known as (Hoyer Lift), fully mechanized total lifts, and Sit-to-Stand Lifts.” The policy further stated, “Lifts are utilized to provide a safe and ergonomic method to assist residents to transfer, stand, and toilet without physically or manually lifting them. Manual lifting can cause injury to both residents and staff and should be avoided. Staff are required to visually inspect slings, pads, belts, or chains and inspect prior to use. The policy documented, staff were not required to use a mechanical lift when there was evidence of broken, bent, or torn pieces of equipment that might render the device unsafe. “ 1.Record Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed R#32’s had a Brief Interview of Mental Status (BIMS) was a score of 14/15, which indicated the resident was cognitively intact. During an interview on 7/18/2025 at 10:48 AM, R#32 stated s/he was the roommate of R#7, and they had been roommates for several months. R#32 stated s/he remembered when staff used a Hoyer lift and dropped R#7 on the floor. R#32 stated R#7 cried in pain and was sent to the hospital. 2. Record review of R#7s face sheet showed an admission date of 10/06/2023, diagnoses included End Stage Renal Disease stage five, Dependence on Renal Dialysis and Chronic Pain. Record review of R#7s care plan, initiated on 12/9/2021, documented R#7 required assistance with activities of daily living (ADL) and had a Self-Care Performance deficit. The care plan directed staff to use a Mechanical lift (Hoyer Lift) with two staff during transfers. Record Review of the quarterly MDS dated [DATE], revealed R#7s had a BIMS score of 15/15. R#7 was impaired on one side and required total assistance with ADLs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of R#7s progress notes dated 10/13/2024 at 11:04 AM, showed Registered Nurse (RN)#7 documented that she was called to R#7s room by staff and was informed R#7 was on the floor. RN#7 found R#7 lying on iron bars which supported the Hoyer lift. R#7s shoulder and head were on the iron bars supporting the Hoyer lift. R#7 complained of leg pain in her left leg. R#7 stated she hit her shoulder. R#7 was verbal, alert and oriented. R#7 was in pain and distress. R#7s daughter was present and was aware of the fall. R#7s physician was notified and R#7 was sent out to the emergency department for further evaluation. Record review of the facility, Employee Corrective Action Form (ECAF) dated 10/14/2024 documented GNA#10 was suspended after GNA#10 dropped R#7 on the floor when she used a Hoyer lift to transfer R#7 without assistance from another staff and caused a fracture of the shoulder. Record review of the facility ECAF, dated 10/16/2024 documented GNA#10 was terminated after GNA#10 violated facility policy regarding safety and carelessness. Record review of R#7s progress notes dated 10/17/2024 at 01:00 PM, showed Nurse Practitioner (NP)#27 documented she made a follow up visit after R#7 experienced a fall from a Hoyer lift over the weekend and wrote the fall resulted in a left femoral condylar fracture and a left clavicle fracture. During an interview on 7/18/02025 at 10:13 AM, RN#7 revealed she was familiar with R#7 and worked with her in the past. RN#7 stated she recalled sometime in October 2024; she was called to R#7s room when GNA#10 dropped R#7 while she attempted to transfer R#7 from her bed to the chair. RN#7 stated GNA#10 was the only staff member in the room when the accident occurred. RN#7 explained R#7’s daughter was in the room visiting. RN 7 explained, the sling was not properly fastened and hooked and stated the Hoyer lift did not malfunction. According to RN#7 the Hoyer lift functioned properly and she concluded one of the Hoyer slings was not properly fastened when it came off and caused R#7 to hit the floor. During an interview on 7/18/2025 at 1:31 PM, the Human Resources Manager (HRM)#11 revealed that GNA#10 was terminated when she violated facility policy and explained GNA10 attempted to transfer R#7 using a Hoyer and dropped R#7 on the floor. According to HRM#11, GNA#10 did not request help from other staff during the transfer. During interview and observation on 7/21/2025 at 8:45 AM, R#7 was observed in her bed and stated she recalled sometime in October 2024, GNA#10 dropped her from the Hoyer lift, and she landed on the iron bars and broke her leg and collarbone. R#7 stated she spent several months in pain. During interview and observation on 7/21/2025 at 9:15 AM, Maintenance supervisor (MS)#13 revealed all the mechanical lifts were properly serviced and were in good working condition. During an interview on 7/21/2025 at 10:30 AM, GNA#15 revealed that GNA#10 did not ask for help. She stated she was on duty and worked on the same floor when GNA#10 dropped R#7 on the floor using a Hoyer lift. GNA#15 stated facility policy required two staff persons when assisting residents with a Hoyer at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/22/2025 at 2:38 PM, GNA#10 explained on 10/14/2024 she used a Hoyer to transfer R#7 from the bed to the chair by herself. She stated she raised R#7 approximately six feet from the ground and the strap came loose and R#7 landed on the floor. According to GNA#10, R#7 cried and stated her leg was in pain. According to GNA#10, she was suspended immediately and was terminated the next day. GNA#10 stated she asked for help, and no-one came to assist her. During an interview on 7/22/2025 at 1:15 PM, Administrator#1 revealed facility policy required two staff persons to assist residents when using a Hoyer lift. Administrator#1 stated GNA#10 should have requested assistance from another staff member and concluded the accident was avoidable. Administrator stated Quality Assurance and Performance Improvement (QAPI) will be ongoing. During an interview on 7/25/2025 at 8:30 AM, the Director of Nursing (DON)#2 stated the accident was avoidable as R#7 was a two-person assist with transfers. During an interview on 7/25/2025 at 8:30 AM, DON 2 stated the facility will continue with ongoing audits and monitoring staff during resident transfers and concluded all staff were in serviced and continuous education will be provided. Record review of facility in-service record dated 10/14/2024 showed staff were in serviced on how to use a Hoyer lift with two staff at all times. Record review of facility in-service record dated 10/17/2024 showed staff were in serviced regarding a Hoyer lift size guide and how to properly use a Hoyer lift with two staff at all times. Based on the above actions taken by the facility and verified by surveyors on site, it was determined that the facility's deficient practice was past-noncompliance with a compliance date of 10/17/24.