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	03/06/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on the review of a facility reported incident 2699068, medical record review, and interviews with facility staff, it was determined that the facility failed to ensure that residents were free from exploitation. This was evident for 1 (Resident #7) of 1 allegation of exploitation reviewed during the complaint survey.The findings include:The facility reported incident #2699068, which was investigated starting on 3/2/26 at 9:00 AM. According to the incident summary, Resident #7 (R#7) came to the Administrator's office and stated h/she and Geriatric Nursing Assistant (GNA) #13 had been in an on-and-off relationship for a year and stated they had had sexual intercourse many times. The relationship was determined to be consensual, occurred intermittently over an extended period, and did not involve any observed concern related to supervision, care delivery, or resident safety on units. GNA #13 also asked for approximately $400.00 in August 2025, and s/he gave willingly. R#7 had been deemed capable and had a Brief Interview Mental Status (BIMS) score of 15/15. The resident is alert and oriented, has decision-making capacity, and has denied feeling coerced, threatened, or physically harmed. Staff witness statements were reviewed, and 2 staff members had suspicions about the relationship between R#7 and GNA #13 but did not report it. A review of R#7's statement summary dated 12/22/2025 revealed h/she wanted to speak to Admin2. The Resident stated h/she heard that GNA13 had reported allegations regarding drugs being present in their room. H/she stated those allegations were untrue and h/she wished to clear the air. H/she stated h/she and GNA #13 had been in an on-and-off relationship for one year. The relationship included sexual encounters that occurred on multiple occasions, including within the facility, in h/she's room, as well as at a motel. The relationship was consensual, never felt forced or pressured. H/she was never raped and did not regret the relationship and would not change what occurred if given the opportunity. H/she initiated physical contact and did not want law enforcement involved. R#7 also stated that around August 2025, approximately $400.00 was given to GNA #13. The money was given voluntarily, and it was recorded in text messages.A review of the text messages to and from GNA #13 and R#7 showed that the staff member's number was given to the facility upon hire. A text message dated 8/29/2025 at 12:03 PM revealed that GNA #13 asked to borrow $400.00, and R#7 agreed to give the employee the money. There were other text messages that revealed GNA #13 was planning to go to see R#7 and included explicit language that indicated there was a sexual relationship between the two.A telephone interview with GNA #13 was unsuccessful.An interview with Director of Nursing (DON)2 was conducted on 3/5/26 at 12:44 PM. The DON stated the resident was alert and oriented, had a mutual relationship with R#7, and was not coerced. There was evidence from text messages from the two that revealed a sexual relationship. She also stated that she expected the staff to keep it professional with Residents, not engage in sexual relations, and not receive or give money to Residents. An interview with Executive Director (ED)1 was conducted on 3/5/26 at 1:12 PM. He stated that all staff are expected to remain professional. They are not to have relationships with residents and/or give or accept any money from the residents.

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 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 interview, the facility failed to timely report an injury of unknown origin and an incident of resident exploitation to the State Survey Agency. This was true for two (Resident #7 and #8) of six residents sampled for reporting during the complaint survey.The findings include: 1) Based on record review, Resident #8 reported left leg pain on January 14, 2026. The resident was evaluated by the facility provider, and an X ray was ordered. The X ray completed on January 15, 2026, showed: Chronic fractures of the proximal tibia and fibula. A possible acute fracture of the distal fibula. A recommendation for follow up imaging or magnetic resonance imaging (MRI). The facility's administrative staff confirmed during interviews that they were aware of the radiology findings on January 15, 2026. Review of the facility's incident reporting log showed that the facility did not submit a report to the State Survey Agency until January 19, 2026, four days after becoming aware of the fractures. Interview on 3/5/26 at 12:51PM Director of Nursing (DON) stated that reportable for Resident #8 was reported late to the state. DON stated they should have reported immediately. DON stated the incident occurred on 1/14/26 and that they were notified by the floor nurse on 1/15/26. DON stated that an X-ray was ordered on 1/15/26, but the facility wanted to clarify whether the injury was pre-existing. DON stated they did not report the incident until 1/19/26, four days after being notified. 2) The facility reported incident 2699068 was investigated starting on 3/2/26 at 9:00 AM. According to the incident summary, Resident #7 came to the Administrator's office and stated h/she and Geriatric Nursing Assistance (GNA) #13 had been in an on-and-off relationship for a year and stated they had had sexual intercourse on occasions. The relationship was determined to be consensual, occurred intermittently over an extended period, and did not involve any observed concern related to supervision, care delivery, or resident safety on units. GNA#13 also asked for approximately $400.00 in August 2025, and h/she gave willingly. Resident #7 had been deemed capable and had a Brief Interview Mental Status (BIMS) score of 15. There were two witness statements that stated they felt there was a sexual relationship between the Resident and a staff member and did not report it. A review of a witness statement from HK19, dated 12/22/2025, revealed that she was aware GNA #13 was having an inappropriate personal relationship with Resident #7 and did not answer the question of whether she had reported it prior to today. HK19 did not return calls for an interview. A review of a witness statement from Licensed Practical Nurse (LPN) #8, dated 1/1/26, revealed that she heard a rumor of an inappropriate relationship between Resident #7 and GNA #13 last week. An interview was conducted with LPN #8 on 3/5/26 at 11: AM. She stated she should have reported it when she first heard the rumors to protect the residents from harm. She did not think it was an issue because the resident was alert and oriented. An interview with Director of Nursing (DON) #2 was conducted on 3/5/26 at 12:44 PM. The DON stated she believed since Resident #7 was alert and oriented and had a mutual relationship with GNA (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#13, it was not coerced. She also stated she expected the staff to keep it professional with Residents and not to receive or give money to or from residents. The DON also stated LPN #8 should have reported the rumor to her or the Executive Director (ED) when she first heard about it. An interview with ED1 was conducted on 3/5/26 at 1:12 PM. He expected the staff to report concerns as soon as they saw or heard anything to rule out abuse.

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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 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, the facility failed to ensure safe transport practices for 1 (Resident #8) of 6 residents reviewed during the complaint survey. This failure resulted in actual harm to Resident #8.The findings include:During record review it was revealed that on 1/13/26, Resident #8 (R#8) was transported offˆcampus for an appointment in a wheelchair without leg rests, although the resident normally required stretcher transport due to limited ability to lift or maintain leg position. Shortly after transport began, the resident's left foot became caught under the wheelchair frame, and the resident reported immediate pain.During an interview on 3/3/26 at 10:14 AM, R#8 stated that Geriatric Nursing Assistant (GNA) #12 appeared to be in a hurry and did not use leg rests. The resident reported yelling stop when their leg became caught and stated that GNA #12 did not initially assess them for injury. Another staff member later attached the leg rests, and the resident was transported to the appointment without further assessment. The resident reported increasing pain throughout the day, and an Xˆray dated 1/15/26 revealed a fracture.Record review revealed R #8's Minimum Data Set (MDS) dated [DATE] documented the resident was cognitively intact (Cˆscore 15/15), used a wheelchair for mobility, and was dependent for toileting, and dressing.Diagnostic imaging included an Xˆray on 1/15/26 showing chronic fractures with a possible acute femur fracture, and a computed tomography (CT)/ magnetic resonance imaging (MRI) on 1/19/26 confirming a nondisplaced femoral condyle fracture. Medical orders dated 1/23/26 required a left knee immobilizer every shift.Review of the resident's care plan and transportation assessment showed that R#8 typically required stretcher transport due to limited leg mobility. The facility did not follow the resident's assessed needs and did not ensure the use of appropriate assistive devices.The facility's investigative report dated 1/19/26 documented that GNA #12 transported the resident in a wheelchair without leg rests and was written up. During an interview on 3/3/26 at 1:44 PM, GNA #12 acknowledged that leg rests should have been used because the resident could not selfˆpropel. GNA #12 stated they asked the resident to hold their legs up and began pushing the wheelchair approximately two doorways before the resident yelled out. GNA #12 stated they retrieved leg rests and asked the resident if they were okay before continuing transport and reported being reˆeducated and disciplined.During an interview on 3/5/26 at 11:50 AM, the Director of Nursing (DON) stated that residents transported in wheelchairs must have leg rests unless they refuse. The DON stated that R#8 was normally transported via stretcher and that GNA #12 should have known this by reviewing the Kardex. The DON stated that the resident did not report pain until the night shift, at which time the physician and family were notified. Diagnostic imaging confirmed a nondisplaced femoral fracture.