

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Hagerstown Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on complaints, a facility reported incident (FRI), reviews of a clinical record, reviews of facility investigation documents, and staff interview, it was determined that the facility staff failed to provide adequate supervision to Resident #5 to prevent Resident #5 from entering other resident rooms. On 07/01/26, Resident #5 was left unsupervised which allowed him to enter Resident #4's room and expose his groin area to Resident #4 and his family member. This was evident for 1 (Resident #5) of 8 residents reviewed during a complaint survey. The findings include: In an interview with Resident #4 on 07/15/26 at 3:16 PM, Resident #4 complained that at the beginning of the month Resident #5 entered Resident #4's room and exposed his groin area to Resident #4 and his visiting family member. A review of Resident #5's clinical record on 07/16/26 revealed Resident #5 was ordered to have a 1:1 sitter at all times due to a history of behavioral disturbances and that he cannot recall events. In an interview with GNA#3 on 07/16/26 at 11:49 AM, GNA#3 stated that they were assigned to watch Resident #5 at all times on 07/01/26 during the evening shift. GNA#3 stated that Resident #5 was pacing back and forth and kept asking for a pepperoni pizza. GNA#3 stated that she called in an order to a local restaurant asking for the restaurant to deliver a small pepperoni pizza to the facility. When the delivery service arrived, GNA#3 stated she spoke to the nursing supervisor and requested that he please take her place sitting with Resident #5. The nursing supervisor stated yes and GNA#3 went to the front door to pay for Resident #5 pepperoni pizza. GNA#3 stated this is when Resident #5 exited his room and entered Resident #4's room and exposed his groin area to Resident #4 and the family member. On 7/17/26 at 11:17 AM, the Office of Health Care Quality also received a facility reportable incident (FRI) of an allegation of resident-to-resident abuse. The allegation included information that Resident #5 had exposed his groin area to other residents and family members. A review of the Facility Reported Incident documents for 3096790 on 07/20/26 at 3 PM, revealed that on the evening of 07/01/26 at approximately 5 PM, Resident #5 entered Resident #4's room and exposed his groin area to Resident #4 and Resident #4's visiting family member.		

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: 215336
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, observation, record review, and interviews, it was determined that the facility failed to ensure that a resident was served a meal according to a predetermined menu that incorporated the resident's preferences. This was evident for 1 (Resident #3) of 8 residents reviewed during a complaint survey. The findings include: On 06/24/26 at 4:50 PM, the Office of Health Care Quality received a complaint regarding the lack of quality of care Resident #3 is receiving while residing in the facility. Review of Resident #3's clinical record on 07/15/26 revealed Resident #3 was currently receiving Hospice services since 02/05/26. The current plan for Resident #3 was to be transferred to another SNF that their spouse was currently residing in. An observation made on 7/15/26 at 12:47 PM found Resident #3 sitting in the dinning room being assisted with the lunch meal. GNA#1 was assisting Resident #1 with the lunch meal. A review of Resident #3's 07/15/26 lunch meal ticket revealed the Resident #3 received a mechanical soft diet with nectar thickened liquids. The meal ticket also included that Resident #3 likes additional gravy and to use a translucent small sip cup with 2 handles. Observation of Resident #3's meal tray against the 07/15/26 meal ticket failed to reveal 3 additional items that should have been included on the meal tray. Missing were pureed cranberry crunch bar, 1 serving of a frozen nutritional treat (8 ounces of cranberry juice), and 1/2 cup of mandarin oranges. When asked, GNA#1 was not aware why all of the food items listed on Resident #3's meal ticket were not sent on the lunch meal tray. On 7/15/26 at 1:17 PM, RN#1 brought in the additional 3 missing items for Resident #3's lunch meal. At 1:23 PM, GNA#1 was continuing to assist Resident #3 with their lunch meal. In an interview with the facility Dietician on 07/15/26 at 1:52 PM, the facility Dietician confirmed that Resident #3 had physician ordered dysphagia mechanical ground regular diet with nectar thickened liquids. The facility Dietician stated that the facility speech language pathologist (SLP) evaluated and cleared Resident #3 to receive fruit like mandarin oranges and bananas for meals. The facility Dietician also provided the nurse surveyor documentation for Resident #3 that listed the following: Diet-[NAME], Mechanical textures, nectar thick liquids, Adaptive equipment included a scoop plate, two handled cup, weighted utensils, Supplements included a frozen nutritional treat once a day and Medpass 2.0, 120 milliliters once a day, Fruit included chilled pears at dinner, mandarin oranges at lunch, and a banana at breakfast. The facility Dietician also produced a copy of Resident #3's nutritional care plan that listed all of the meal choices and adaptive equipment listed during the interview.		