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	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hagerstown Healthcare Center	750 Dual Highway Hagerstown, MD 21740

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, it was determined that the facility failed to label and date foods stored in facility refrigerators, ensure cleanliness of the kitchen environment and equipment, and maintain safe food storage temperatures in the walk-in refrigerator. This was evident during kitchen tours conducted throughout the facility's annual survey.The findings include:A. On 11/19/25 at 8:24 AM, the Surveyor conducted a brief initial tour of the facility kitchen. Upon stepping inside the walk-in refrigerator, the Surveyor observed multiple food items that were not labeled and/or not dated, including:Ground meat in a container labeled only freeze by 10/21/25, with no description of the food item or date when it was moved to the refrigerator. Shredded cabbage in a clear container with no date or label.Chocolate pudding in a metal container covered in plastic wrap with no name label.After leaving the walk-in refrigerator, the Surveyor opened the reach-in refrigerator and observed a container holding a pureed, orange-colored food item. The Surveyor asked Dietary Aide (DA #12) to identify the item. She stated, I think it's oranges, and immediately labeled the container as oranges with the date 11/19/25. When asked how she knew it was from that date, she stated she was unsure and would need to find out. She later returned and reported, It was probably from yesterday. When asked if it was appropriate to label an item with today's date if it was from yesterday, she stated, No, and confirmed that items should be labeled and dated when placed in the refrigerator.During this observation, a gentleman approached and identified himself as a Dietary Manager (DM #13) who was in the facility to help. The Surveyor showed him the undated and unlabeled food items in the walk-in refrigerator. He agreed that the items should have been labeled and dated and acknowledged that the practice was unsafe. He stated that many staff members were new and still learning. When asked whether the ground meat had been removed from the freezer to thaw for the day's meal or whether it was expired, he was unsure.On 11/21/25 at 11:50 AM, the Surveyor conducted an interview and performed a walk-through of the kitchen with the Dietary Manager (DM #14) and expressed concerns that there were food items stored in the refrigerators that were not dated and/or labeled. He stated that the other DM (#13) had advised him of the Surveyor's concerns, and he also agreed that the expectation is for foods to be both dated and labeled for storage. The Surveyor observed that the food items had been discarded after making DM #13 aware of the concerns.On 11/24/25 at 10:50 AM, the Surveyor conducted an interview with the Regional Dietary Manager (RDM) and expressed concerns about the unlabeled and undated food items, and he agreed that it is the expectation to label and date all food items in the refrigerators.On 11/24/25 at 1:42 PM, the Surveyor conducted an interview with the Nursing Home Administrator (NHA) and expressed concerns that the staff had missed labeling and/or dating several food items in both the walk-in and reach-in refrigerators. She stated that staff had made her aware of the Surveyor's findings and that there had been recent staff turnover but that they are working to ensure regulatory compliance.On 11/26/25 at approximately 8:30 AM, the Surveyor reviewed the facility's Dining Services policy titled Food Storage: Cold Foods (revised 2/2023), which states:All time/temperature control for safety foods, frozen, and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code.All foods will be stored, wrapped, or in covered containers, labeled (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and dated, and arranged in a manner to prevent cross-contamination.B. On 11/19/25 at 8:24 AM, during the initial tour of the kitchen, the Surveyor observed the following:Multiple carts lined along the kitchen entrance containing dirty food plates, cups, and utensils positioned next to a water cart holding what appeared to be clean cups, straws, and sugar packets.Floors visibly soiled with scattered food debris, spills, and unidentified substances.The stove and backsplash coated with black residue consistent with grease and grime; burners and surrounding areas had similar buildup.The adjacent griddle was covered with accumulated grease and grime.The food warmer with splattered substances, hazy residue, dried white drips on the exterior, and food debris inside the unit.Both food steamers with hazy glass doors, visible food particles, and grime on interior and exterior surfaces.A cart used to store clean cups containing dirt particles.The reach-in refrigerator exterior covered with streaks and dried food-like substances.The iced tea cart soiled with splashes and buildup of unidentified substances.During this observation, DM #13 approached the Surveyor. When the Surveyor asked about cleaning checklists, he reported that he was only assisting during survey, did not normally work in the facility, was unsure where cleaning logs would be kept, and would inform DM #14 that the Surveyor asked about the cleaning schedule upon his arrival.On 11/21/25 at 11:50 AM, the Surveyor toured the kitchen with DM #14 and discussed concerns regarding the stove, griddle, steamer, warmer, reach-in refrigerator, clean-storage rack, iced tea area, and overall uncleanliness. DM #14 stated that the facility contracts with a company to clean the floors and suggested the stove may appear dirty due to age, but agreed that cleanliness is an issue and stated that they are working with new staff that need to be trained. The Surveyor requested the facility's daily cleaning logs.On 11/21/25 at 12:13 PM, the Surveyor interviewed the Registered Dietitian (RD) and asked her about her role. During the conversation, the Surveyor asked if she had concerns over the cleanliness of the kitchen, and she stated that she performs sanitation audits in the kitchen and that one of the concerns was that the kitchen needed deep cleaning.On 11/21/25 at 1:40 PM, DM #14 provided the Surveyor with a blank cleaning checklist titled Daily Cleaning Assignments - Week of ____. The list is extensive and includes multiple cleaning responsibilities for the staff for all shifts. Additionally, the document states: All cleaning assignments must be completed and checked by the food service director or supervisor before you leave. The Surveyor asked for the completed log for November, and he stated that the log had not been filled out by the staff for any days of November 2025.On 11/24/25 at 10:50 AM, the Surveyor conducted an interview and tour with the Regional Dietary Manager (RDM) and expressed concerns about the cleanliness of the kitchen. He stated that DM #14 was in over the weekend and that he cleaned the stove and asked the Surveyor to look at it. The Surveyor observed that the stove backsplash had been thoroughly cleaned and that all the black residue had been removed. The Surveyor showed the RDM the photos taken the first day of the survey that demonstrated how dirty the stove and backsplash, warmer, steamer, reach-in refrigerator doors, clean dish cart, and iced tea cart were during the initial tour. He acknowledged that it should never get to that state of uncleanliness.During the tour, the Surveyor noted that the shelf under the iced tea maker had grime buildup and needed to be cleaned and pointed it out to the RDM. The Surveyor expressed concerns that the cleaning checklist had not been completed for the month of November, and he stated that there has been a lot of turnovers with staffing but that they are working on stability and would be implementing the cleaning checklists. He added that the kitchen floors were deep cleaned over the weekend.On 11/24/25 at 1:42 PM, the Surveyor interviewed the NHA and shared photos from the initial tour. She agreed the kitchen should not have reached that level of uncleanliness if cleaning checklists had been completed regularly. She acknowledged that DM #14 had notified her that cleaning checklists were not completed for November and stated they were working on new processes to ensure the kitchen is cleaned.On 11/26/25 at approximately 8:30 AM, the Surveyor reviewed the following Dining Services policies and procedures:Environment (revised 9/2017) All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.Food: Preparation (revised 2/2023) All utensils, food contact equipment, and food contact (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	surfaces will be cleaned and sanitized after every use.Equipment (revised 9/2017) All food service equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris.C. A walk-in refrigerator for long-term care facilities must be maintained at 41 F or below to ensure safe food storage. Temperatures between 41 F and 140 F are considered the danger zone, where bacterial growth accelerates.On 11/19/25 at 8:24 AM, the Surveyor observed that the walk-in refrigerator door latch was not closing properly, and the door was not sealing. Dietary Aide (DA #17) reported it had been that way for a while. The Surveyor observed the exterior thermometer read 44 F, and the interior thermometer read 42 F, confirmed with a second thermometer. When reviewing the temperature log, the Surveyor observed that the PM shift on 11/18/25 had not recorded the temperature, and the morning shift on 11/19/25 recorded 41 F.The Surveyor expressed concerns to DM #13 and he stated that he was only assisting during the survey and would notify DM #14 of the Surveyor's concern when he arrived.On 11/21/25 at 11:40 AM, DM #14 stated that the latch on the walk-in refrigerator had been repaired. The Surveyor expressed concerns that it was unknown whether temperatures had remained safe due to the unsealed door and the missed PM log entry on 11/18/25. The Surveyor also expressed concern regarding the above-41 F temperatures observed on 11/19/25. DM #14 stated he was aware and commented that new staff were being trained and new processes implemented.On 11/24/25 at 10:50 AM, the RDM stated he was made aware of the concern about the refrigerator temperatures and stated that the facility was working on implementing changes due to recent staff turnover.On 11/24/25 at 1:42 PM, the NHA reported that she was aware of the concerns with the refrigerator temperature and that they were working to ensure compliance with safe food-storage temperature requirements.On 11/26/25 at approximately 8:30 AM, the Surveyor reviewed the Dining Services policy titled Food Storage: Cold Foods (revised 2/2023), which states:All time/temperature control for safety foods will be stored in accordance with the FDA Food Code.All perishable foods will be maintained at 41 F or below, except during preparation and service.A written record of daily temperatures will be maintained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, policy review, and interviews, the facility failed to prevent the spread of infection, as evidenced by the failure of licensed nursing staff to perform hand hygiene during medication administration for 3 (Residents #10, #11, and #85) of 4 residents observed. On 11/19/2025 at 8:15 AM, the surveyor arrived on the first floor and observed medication administration by CMA #2, who dispensed medication for Resident #10. Hand hygiene was not performed as the CMA began pulling blister packages from the medication cart for this resident. Hand hygiene was also not performed before administering medications to Resident #10. On 11/19/2025 at 8:30 AM, Hand hygiene was not performed when Nurse #1 approached the medication cart and administered a PRN medication (oxycodone 5) for Resident #11. At 0835 on 11/19/2025, when the CMA #2 began administering medications to Resident #85, hand hygiene was not performed. 11/21/2025 8:23 AM, the facility's Infection Prevention and Infection Control Program policy was reviewed. An IP (Infection Preventionist)/ designee will coordinate and be responsible for surveillance and the reporting of infectious outbreaks 1. The IP designee is a nurse in the facility with knowledge of the geographic population and with the rules and regulations of LTC infectious concerns Surveillance of Infections: i. There is ongoing monitoring of infections for residents and employees, and follow-up documentationii. Prevention of spread of infections is accomplished by education and implementation of the use of hand hygiene, standard precautions, and transmission-based precautions as appropriate, with treatment and follow-up, and employee work restrictions for illness. 11/21/2025 1:45 PM, a review of the facility's Medication Administration policy revealed section II, bullet: f, h'Preparation': a. Prepare a clean work surfaceb. Prepare liquids and foods to be used with medications ˆi. Maintain proper temperatureˆii. Check dates on food productsˆiii. Keep food or liquid products covered or closed when not in usec. Obtain appropriate supplies, including but not limited to:ˆi. Glovesˆii. Cups ˆiii. Strawsˆiv. Sharps containerd. Identify the resident by picture and state their name e. Provide for dignity and privacyf. Perform appropriate hand hygiene before beginning medication administrationg. Observe Standard Precautions, including safe sharp useh. Perform hand hygiene before and after each resident's medication is administered 11/21/2025 3:00 PM An interview was conducted with Staff #11. She was asked how infection prevention is accomplished for staff who administer medications. Staff #11 stated, Routine in-service education is provided to nursing staff on standard infection control practices monthly. Following up on the monthly in-service education, the surveyor asked whether hand hygiene observation audits were conducted and documented as outlined in the provided policy. Staff #11 stated, I routinely make observations of medication passes on the units and will engage verbally with nursing staff in a teachable moment if they are observed not to perform hand hygiene, but I do not track or document the observations or audits. During the interview, the surveyor disclosed to Staff #11 that Nurse #1 and CMA #2 were observed not performing hand hygiene during medication administration for Residents #10, #11, and #85. She acknowledged the deficiency. On 11/26/2025, during an interview at approximately 10:45 AM, the Nursing Home Administrator and Director of Nursing were made aware of observations and findings.

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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. Based on interviews and record review, it was determined that the facility failed to notify a Resident's representative of a documented change in the Resident's condition. This was evident for one (Resident #22) out of one Resident reviewed for Notification of change.The findings include:In an interview on 11/19/2025 at 9:51 AM, the representative for Resident #22 stated that the Resident had wound dressings on both legs; however, she was unaware of the onset of the wounds or their type.A review of Resident #22's record included a change in condition evaluation form completed on 6/26/24 that recorded that Resident #22's bilateral legs and feet has dry flakes and open areas with purulent discharge with an odor. The review showed that the change began on 6/26/24 and was reported to the attending provider for Resident #22 on that date. The section of the change in condition evaluation form that documented the name of the family/health care agent notified was left blank.A continued review showed a skin/wound note dated 6/26/24 that stated that Resident #22 was seen by wound/ treatment nurse per request of floor nurse. Bilateral lower legs has open wounds. Areas cleansed with normal saline, xeroform applied, and covered with rolled gauze. MD/NP (attending provider) made aware. However, the review failed to show that Resident #22's representative was notified of the Resident's change in condition.In an interview on 11/21/2025 at 1:58 PM, the director of nursing (DON) said that any change in a resident's condition should be reported immediately to the Resident's attending provider and the representative. The DON checked the completed change in condition evaluation form for Resident #22 on 6/26/24, the clinical notes, and confirmed that the Resident's representative was not notified of the change in condition on 6/26/24.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to complete Significant Change in Status Minimum Data Set (MDS) assessments within 14 days following a significant decline in the Residents' condition. This was evident for 1 (Resident #5) of 1 Resident reviewed for Hospice, and 1 (Resident #10) out of 5 Residents reviewed for Unnecessary medication regimen review The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected on the MDS drives Resident care planning decisions. The nursing home should complete a Significant Change in Status MDS assessment within 14 days of a major decline or improvement in a resident's status after the determination that a significant change has occurred.1) A record review for Resident #5 on 11/24/2025 at 2:25 PM included a hospice admission note that indicated that the Resident was admitted to hospice care effective 7/31/25. The continued review contained a Significant Change in Status MDS assessment dated [DATE] for Resident #5. The MDS assessment was completed and signed in sections Z0500B & V0200B2 on 8/20/25, 21 days after admission to hospice care and 6 days late.In an interview on 11/25/2025 at 12:10 PM, staff #18, an MDS Coordinator, confirmed that the Significant Change in Status MDS assessment for Resident #5, dated 7/31/25, was completed late.2) Record review for Resident #10 on 11/25/2025 at 7:22 AM showed that the Resident was readmitted from the hospital to the facility on [DATE].Further review included a Significant Change in Status MDS assessment for Resident #10 dated 10/7/25. The MDS assessment was completed and signed in sections Z0500B & V0200B2 on 10/27/25.During an interview on 11/25/2025 at 10:30 AM, staff #18 reported that Resident #10 had a change in his/her ability to transfer, warranting a Significant Change in Status MDS assessment. Staff #18 continued to state that the determination date for Resident #10's Significant Change in Status was 10/5/25, the day of readmission to the facility. However, an earlier review showed that the Significant Change in Status MDS assessment for Resident #10 dated 10/7/25 was completed on 10/27/25, 22 days after readmission to the facility and 8 days late.Staff #18 confirmed that Resident 10's Significant Change in Status MDS assessment was completed late.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review and staff and resident interview, it was determined that the facility failed to accurately document a resident's status on the Minimum Data Set (MDS) assessment for 1 resident (Resident #81) of four residents reviewed for accidents during the survey.The findings include:The MDS is a federally mandated assessment tool that gathers information on each resident's needs that helps determine care planning decisions. Accurate MDS assessments should reflect the quality care that each resident receives. The assessment reference date (ARD) is the specific date used to assess a resident's current status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 11/19/25 at 8:37 AM Resident #81 was observed in bed. Talkative and pleasant. Personal items, fresh water, call bell observed within reach and 1/4 bilateral bedrails observed attached to the bed. On 11/21/25 at 12:55 PM a review of Resident's #81 last weight was 347.2 lbs. The care plan revealed on 2/24/24, an intervention was initiated for bilateral 1/4 siderails to bed to promote independence. Further review of MDS with ARD of 9/29/25, Section P, did not reflect Resident #81 had bedrails. On 11/21/25 at 1:04 PM, during an interview, MDS nurse (Staff #6), indicated that data used to complete the MDS assessment was gathered from the medical record which included: nurses notes, census, medication records, appointments, physician orders and the care plan. It was acknowledged that bedrails were part of the care plan and the MDS, Section P, did not document bedrails. Staff #6 acknowledged that Resident #81's MDS assessment was inaccurately documented. On 11/21/25 at 1:20 PM the surveyor confirmed observation of bedrails on Resident #81's bed and the resident stated, I need those to move in bed.On 11/25/25 at 2:17 PM the Nursing Home Administrator and Director of Nursing were made as of the concern.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to provide medically related social services to a resident triggered for required PASARR screening. This finding was evident for one (Resident #54) of three residents reviewed for PASARR screening during the survey. The findings include: A Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care and/or ensure the most appropriate care setting to meet their needs. Brief Interview for Mental Status (BIMS) is an evaluation tool that indicates one's cognitive (thinking) ability ranging from 0 to 15. Zero represents no cognitive ability and 15 represents intact cognitive ability.On 11/19/25 at 9:23 AM Resident #54 was observed awake in bed; it was in the lowest position and had clean linens. Resident was alert, dressed and appeared to be agitated. The resident stated, my black slacks are missing. Surveyor observed two stuffed clear bags on the floor. Eventually, the resident discovered the slacks in one of the bags. Resident refused assistance to place the belongings in the closet or dresser.On 11/19/25 a review of Resident #54's medical record revealed a recent admission on [DATE] post hospitalization after a recent fall. Diagnosis included high blood pressure, hemorrhagic brain bleed, Alzheimer, anxiety and depression. The resident's brief interview mental status (BIMS) was 9, that indicated moderate impairment to one's thinking ability. A signed certification dated 10/23/25 revealed that the resident lacked capacity. On 11/25/25 at 7:59 AM a review of the PASARR I outcome completed on 10/10/2025 read: Letter Rationale: 30-day Provisional Hospital Exempt PASARR, valid electronic health document form attached. If nursing facility stay extends past 30 days (11/9/25) a new PASARR will be required.On 11/25/25 at 8:29 AM in an interview, the Director of Social Service, (Staff #4) after reviewing the PASARR I outcome, stated, I missed it, and acknowledged that the facility was required to complete a second PASSAR. On 11/25/25 at 2:18 PM the Nursing Home Administrator and Director of Nursing were made as of the concern. On 11/26/2025 at 10:40 AM Staff #4 confirmed PASSAR was completed after surveyor intervention.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and record review, it was determined that the facility failed to accurately reflect a resident's discharge plan on their individualized care plan. This was evident for one (Resident #32) of three residents reviewed for discharge planning.The findings include: Based on interviews and record review, it was determined that the facility failed to accurately reflect a resident's discharge plan on their individualized care plan. This was evident for one resident (Resident #32) of three residents reviewed for discharge planning. The findings include: Resident #32 has medical diagnoses of Cerebral Palsy, a neurological disorder that affects movement, posture, and muscle tone due to permanent brain damage occurring during fetal development or infancy, and Fragile X Chromosome, which prevents the production of a protein crucial for brain development. This can lead to a range of intellectual, developmental, and behavioral problems, including learning disabilities, speech difficulties, and autistic-like behaviors. A care plan is a personalized document that outlines a resident's specific medical, social, and personal needs, developed with the resident and their family. The care plan guides staff in providing comprehensive and individualized care. The plan is not static; it is based on comprehensive assessments and is regularly reviewed and updated to reflect the residents' changing needs. On 11/20/25 at 11:25 AM, the surveyor conducted an interview with Resident #32's family member, who expressed concerns that although they feel the facility provides good care, the facility does not have the capability to meet Resident #32's specific needs. The family member stated that they had previously discussed these concerns with the facility and were told the facility would work on arranging a transfer to a more appropriate setting based on the residents' required level of care. They stated that the facility was supposed to follow up with them, but they had not received any additional information. On 11/21/25 at 3:52 PM, the surveyor conducted a medical record review. The care plan, which had been revised on 11/13/25, stated, I have no plans for discharge secondary to LTC (long-term care). The surveyor was unable to find documentation to support that there was a plan to discharge the resident to a different facility. On 11/25/25 at 9:06 AM, the surveyor conducted further review of the resident's records, which showed notes from a care plan meeting stating that the desire was for the resident to discharge to a Developmental Disabilities Administration (DDA) group home. The care plan meeting note specified: Resident/family does voice desire to discharge to a DDA group home. Letter was sent to [name withheld] County DDA to add resident to wait list. Social work to follow up. The Developmental Disabilities Administration is a state-level agency that provides services and support to individuals with developmental disabilities. A developmental disability is a severe, chronic disability that makes independent living difficult without support. On 11/25/25 at 9:40 AM, the surveyor interviewed the Director of Social Services (DSS) and asked if (continued on next page)

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	215336	A. Building B. Wing	11/26/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she participates in care planning with residents. She stated that she does. The surveyor asked what her process is for developing a discharge plan. She stated that long-term care residents are reviewed upon admission, quarterly, annually, and with a change in condition. She stated that the plan is individualized for each resident and incorporated into the care plan. The surveyor then asked about Resident #32's plan for discharge, and the DSS stated that she is in the process of coordinating approval of a waiver with DDA. She stated that she had sent a letter to notify DDA that the resident is now stable at the facility and is able to discharge into DDA services. The surveyor asked if it would be expected that the care plan reflects these wishes and the steps (goals) required to make that happen, and the DSS stated yes, the care plan should have been updated. The surveyor showed the DSS that the care plan, updated on 11/13/25, stated that the plan was for Resident #32 to remain in long-term care. She stated that the progress notes reflect the accurate plan but acknowledged, You are correct, the care plan should have carried over the new discharge plan. She stated that she would work on getting it updated. She also stated that Resident #32 needs care that the facility cannot meet to have the best quality of life specific to their needs. On 11/25/25 at 12:16 PM, the NHA provided the surveyor with an updated care plan for Resident #32 and stated that the DSS had shared the surveyor's findings regarding the care plan not reflecting the resident's discharge plan and that it had been corrected.

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	215336	A. Building B. Wing	11/26/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure interdisciplinary care plan meetings were conducted following the completion of Minimum Data Set (MDS) assessments. This was evident for 3 (Resident #11, #5, and #10) out of 41 Residents reviewed during the recertification survey.The findings include:A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. It must be developed within 7 days of completion of a resident's comprehensive Minimum Data Set (MDS) assessment. It must be reviewed and revised by the interdisciplinary team (IDT), including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable) after each assessment, including both the comprehensive and quarterly review assessments.The Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions. 1) In an interview on 11/19/2025 at 3:38 PM, Resident #11 was asked if s/he participated in his/her care plan meetings. The Resident responded that s/he has had very few care plan meetings since residing in the facility. A review of Resident #11's record showed that s/he had resided in the facility since September 2022. A continued review included care conference notes for Resident #11 from January to November 2025, which recorded that the IDT conducted reviews of the Resident's care plans and care plan meetings were held on 4/8/25, 6/17/25, and 9/16/25. Further review of the MDS history for Resident #11 noted that the following MDS assessments were completed for Resident #11:-A quarterly MDS dated [DATE]-A quarterly MDS dated [DATE]-A quarterly MDS dated [DATE]-An annual MDS dated [DATE]-A quarterly MDS dated [DATE].The review lacked documentation indicating that an IDT care plan meeting had occurred following the completion of the MDS assessments dated 1/13/25 and 9/20/25.In an interview on 11/24/2025 at 10:01 AM, staff #4, Social Services Director, reported that IDT care plan meetings were scheduled for Residents based on their MDS schedules. However, the interview and earlier record review lacked documentation that care plan meetings had occurred following Resident #11's MDS assessments in January and September 2025.During a subsequent interview on 11/24/2025 at 1:20 PM, staff #4 confirmed that there was no documentation to show that care conference meetings had occurred following Resident #11's MDS assessments dated 1/13/25 and 9/20/25.2) A record review for Resident #5 on 11/24/2025 at 2:25 PM showed that the Resident was admitted to hospice care effective 7/31/25. The continued review contained a Significant Change in Status MDS assessment dated [DATE] for Resident #5. The MDS assessment was completed and signed in sections Z0500B & V0200B2 on 8/20/25.However, the review failed to show that an IDT care plan meeting had taken place after the Significant Change in Status MDS assessment was completed for Resident #5's admission to hospice care.In an interview on 11/25/2025 at 12:10 PM, staff #18, an MDS Coordinator, reviewed Resident #5's medical record and confirmed that there was no documentation indicating that an IDT care plan meeting had occurred following his/her admission to hospice care.3) Record review for Resident #10 on 11/25/2025 at 7:22 AM included a Significant Change in Status MDS assessment for Resident #10 dated 10/7/25 and completed on 10/27/25.A continued review of care conference notes for Resident #10 lacked documentation for an IDT care plan meeting held after the Significant Change in Status assessment was completed.An interview with staff #18 on 11/25/2025 at 10:30 AM revealed that a Significant Change in Status MDS assessment was completed for Resident #10 due to a change in his/her ability to transfer. A subsequent interview on 11/25/2025 at 12:24 PM with staff #18 confirmed that no care conference meeting occurred following the completion of the MDS for Resident #10's Significant Change in Status on 10/27/25.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, it was determined that the facility failed to provide an ongoing program of activities that met residents' needs and preferences. This was evident for 1 (#10) out of 2 residents reviewed for activities.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care.During an initial tour of the first-floor unit on 11/20/2025 at 10:30 AM, Resident #10 was observed lying in bed and not involved in any activity.A record review on 11/25/2025 at 7:22 AM included a hospital discharge summary that recorded that Resident #10's diagnoses included Altered mental status with underlying Dementia.Further review of Resident #10's MDS assessment dated [DATE] showed that it was very important to him/her to keep up with the news and go outside for fresh air when the weather was good.A review later that day of Resident #10's activity care plan focus initiated on 9/10/24 and revised on 8/27/25 stated, [Resident #10] has little or no activity involvement. [Resident #10] wishes to participate in more activities when feeling better. The goals of the care plan said, [Resident #10] will participate in activities of choice and [Resident #10] will show engagement in activities of interest. The interventions recorded on the care plan stated, Encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities, provide 1:1 in-room visits if unable to attend out-of-room events, provide a schedule of activities available. The care plan was not person-centered and failed to reflect the activity preferences identified on Resident #10's MDS assessment on 6/6/25.A review of activity logs for Resident #10 for August 1 - November 25, 2025, was completed. The review showed that the activities provided to the resident included 1:1 visits, sleep, Talk, TV, and four refusals.Further review of the facility's policies and procedures for Activities Program stated that the Activity Program consists of individual and small and large group activities which are designed to meet the needs and interests of each resident and reflect the schedules, choices and rights of the resident. However, earlier review of activity logs failed to show that Resident #10 engaged in activities, such as going outside for fresh air when the weather was good, which were previously documented as his/her activity preferences on his/her MDS assessment. In an interview on 11/25/2025 at 9:36 AM, staff #7, the Activity Director, expressed understanding of the concern and stated she would update the activity care plan to be more person-centered and would incorporate more of Resident #10's activity preferences in the activities offered.

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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 record review, observations, and interviews, it was determined that the facility failed to provide an assistive device to residents during smoking breaks to prevent accidents. This was evident for one Resident (Resident #40), who was reviewed for accidents.The findings include:A review of a smoker log report provided by the director of nursing (DON) showed that Resident #40 was a smoker and required an apron and staff supervision while s/he smoked.A continued review of a smoking assessment completed on 11/6/25 and provided to the surveyor by DON for Resident #40 showed that the Resident needed an apron and staff supervision during his/her smoking times.On 11/19/2025 at 1:01 PM, during the facility's scheduled smoke break, Resident #40 was with other residents outside the building at the facility's designated smoking area, with staff #3, an activities assistant, in attendance. Resident #40 was observed smoking without an apron. The Resident was asked where his/her apron was and reported that no one had ever offered him/her an apron. Staff #3 was asked about Resident #40's apron and stated she was unaware that the Resident had to wear an apron for smoking.During a subsequent observation of the facility's scheduled smoke break on 11/21/2025, at 9:13 AM, Resident #40 was noted smoking without wearing an apron. Staff #10, an activity assistant, was present and asked about Resident #40's apron. Staff #10 reported that he was unaware that the Resident needed to wear an apron during smoking breaks. Staff #10 was questioned about his process for determining which Resident needed an apron, and he responded that he relied on the facility's smoker log report. Staff #10 then checked the smoker log and confirmed that Resident #40 was on it; however, he was unaware that the Resident had to wear an apron during smoking breaks.In an interview on 11/21/2025 at 9:20 AM, the DON stated that the facility's Activity Department was responsible for supervising residents during scheduled smoking breaks and providing aprons. The concern about Resident #40 not wearing an apron during smoking breaks was shared with the DON, who indicated that Resident #40 refused to wear one. However, the interview failed to show supporting documentation of the Resident's refusal of the apron during smoking breaks.In a subsequent interview on 11/21/2025 at 11:35 AM, the DON reported that the smoker log report and Resident #40's care plan had been updated to reflect Resident #40's refusal to wear an apron during smoking breaks after the surveyor's intervention.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff record review and interviews, it was determined that the facility failed to ensure that a Geriatric Nursing Assistant (GNA) was provided education based on issues identified during the employee's annual performance evaluation. This was evident for one staff member (Staff #8) out of six employees reviewed for sufficient and competent staffing.The findings include:Long-term care facilities are required to provide nurse aide (NA) in-services and education that address areas of weakness identified in the NA's performance reviews.On 11/19/25 at 4:25 PM, the surveyor reviewed employee performance evaluation records, which indicated that Staff #8, a GNA in the facility, had received a verbal warning. The evaluation did not include any details regarding the reason for the warning.On 11/24/25 at 1:45 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA), who stated that she was unsure of the reason for Staff #8's corrective action because she is new to the facility, but that she would look into it. The surveyor asked the NHA to identify the reason for the corrective action and to provide evidence of any in-service or education that was provided as a result of the deficiency noted during the annual performance evaluation.On 11/24/25 at 4:06 PM, the NHA provided the surveyor with a document titled Employee Corrective Action Form, dated 10/7/25, which indicated that Staff #8 had received a verbal warning on 9/8/25 and was subsequently written up again on 10/7/25 for insubordination, stating, Employee behavior was very unprofessional yelling at clinical manager and not following direction. The NHA stated that there was no evidence to support that education or any follow-up training was provided to Staff #8 as required following employee performance evaluations when issues were identified. The NHA acknowledged understanding that this is a requirement.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record reviews and interviews, it was determined that the facility failed to complete the residents' Matrix accurately. This was evident during the recertification survey. The findings include:The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents. The facility completes the resident name, resident room number, and corresponding care categories. All information entered on the form should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of the survey.After the initial entry to the facility for this survey on 11/19/25, the director of nursing (DON) presented a completed matrix dated 11/19/25 at 10.01 AM to the survey team for all residents.A review of the Matrix showed that Residents #35, #57, and #76 received parental feedings (a method of providing nutrients directly into a person's bloodstream through an intravenous (IV) catheter when they cannot eat or receive nutrition through their gastrointestinal (GI) tract).Continued review of the Matrix also noted that Resident #94 received Hospice care.However, further review of a list of Residents receiving hospice care and parental feedings, provided by the DON, failed to show that Residents #35, #57, and #76 received parental feedings, or that Resident #94 received hospice care.In an interview on 11/20/2025 at 4:03 PM, the director of nursing (DON) reported that Resident #94 had been discontinued from hospice care before the surveyors' initial entry into the facility.However, the Matrix was not updated with the change. The DON also confirmed that Residents #35, #57, and #76 did not receive parental feedings. In a subsequent interview on 11/21/2025 at 7:46 AM, the DON reported that she corrected the Matrix after the surveyor's intervention.