

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/21/2025
NAME OF PROVIDER OR SUPPLIER  Complete Care at Hagerstown		STREET ADDRESS, CITY, STATE, ZIP CODE  14014 Marsh Pike Hagerstown, MD 21742	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate allegations of abuse and neglect. This was evident for 1 (Resident #2) of 9 facility-reported incidents reviewed for abuse and for 1 (Resident #4) of 9 facility-reported incidents reviewed for neglect. The findings include: 1). Resident #2 has a history of Alzheimer's disease, depressive disorder, and a femur fracture, requiring assistance with daily activities and personal care.</p> <p>The surveyor reviewed Resident #2's allegations following a facility-reported incident (#2623382) in which the resident alleged that a Geriatric Nursing Assistant (GNA #2) had been rough during care.</p> <p>On 9/21/25 at 1:01 PM, the facility submitted a report to the Office of Health Care Quality (OHCQ) indicating that Resident #2 alleged that GNA #2 had been rough during care.</p> <p>On 10/20/25 at 12:46 PM, the surveyor reviewed the facility's internal investigation. The review revealed that on 9/21/25, Resident #2 reported to the Director of Nursing (DON) that GNA #2 had been rough while providing incontinent care and had dug her fingernails into the resident, causing bleeding. Resident #2 refused assessment at the time but allowed staff to assess the following day, stating they had already cleaned up the blood. The skin assessment showed no breaks, bleeding, or scabbing. Resident #2 later stated that the GNA had not abused them but said, She makes it known that she doesn't really like me, and she gets rough with me during care.</p> <p>The investigation included interviews with several staff members and residents regarding the date of the alleged incident; however, documentation did not show that the facility asked whether staff had ever observed GNA #2 being rough or speaking unprofessionally to residents, or whether other residents had ever felt threatened or injured by GNA #2's care. The facility concluded that the allegation was unsubstantiated without determining whether other residents may have been at risk of abuse.</p> <p>On 10/21/25 at 10:17 AM, the surveyor interviewed the DON regarding her process for ensuring that allegations of abuse are thoroughly investigated. The DON stated that her process includes interviewing staff and residents who may have knowledge of the incident. When asked whether residents are routinely asked if they feel safe or have experienced any type of abuse, she stated, Yes, definitely. Upon reviewing the investigation file, the DON acknowledged that residents had only been asked if they had any issues on Saturday night, and not if they felt safe or had experienced abuse. The DON further stated that the record did not reflect whether staff were asked if they had ever witnessed unprofessional or abusive behavior by GNA #2. The DON agreed that the investigation did not include appropriate questions to rule out whether the allegations could be substantiated.</p> <p>(continued on next page)</p>		

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: 215365
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/21/25 at 10:49 AM, the surveyor discussed the concern regarding the incomplete investigation with the Nursing Home Administrator (NHA). The NHA agreed that without asking residents whether they felt safe or had concerns with GNA #2, and without asking staff whether they had observed concerning behaviors, the facility's investigation did not constitute a thorough investigation.</p> <p>2). A review of a facility-reported incident #2609546 on 10/20/2025 at 9:02 AM, contained an allegation of neglect by Resident #4 involving a staff member.</p> <p>Further review of the facility's investigation into the allegation included statements from the alleged perpetrator and other staff who may have witnessed or been aware of the event.</p> <p>The review also noted that the alleged perpetrator had been suspended pending an investigation into the allegation.</p> <p>A continued review showed that five residents on the alleged perpetrator's assignment on 9/5/25 were interviewed regarding the care they received, and no concerns were identified.</p> <p>However, the review failed to show that the facility had completed a thorough investigation, including a head-to-toe assessment of the other residents who had been cared for by the alleged perpetrator on 9/5/25 and could not speak for themselves when the perpetrator was assigned to take care of about 15 residents that shift.</p> <p>In an interview on 10/20/2025 at 12:42 PM, the Director of Nursing (DON) reported that as part of the investigation into the allegation, she interviewed some residents on the alleged perpetrator's assignment who were alert and could speak for themselves, however she did not do a head-to-toe assessment for the other residents on the GNA's assignment who could not speak for themselves.</p> <p>The DON verbalized understanding of the concern of not thoroughly investigating the allegation.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record reviews and staff and resident interviews, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADL) received the necessary personal care. This deficient practice was evident in 3 of 9 facility-reported incidents reviewed during the complaint survey, affecting Residents #4, #5, and #8. The findings include: 1) A review of the investigation of a facility-reported incident #2609546 on 10/20/2025 at 9:02 AM showed that Resident #4 was transferred to the emergency room on 9/5/25 around 4:00 AM.</p> <p>A review of the follow-up investigation report form contained a statement that EMT [emergency medical technician] reports state that [Resident #4] was soiled upon their arrival, which was confirmed by ER staff.</p> <p>A continued review of Resident #4's medical record contained a hospital emergency triage note dated 9/5/25 that stated that Resident #4 BIBA [brought in by ambulance] for neglect from nursing staff. Pt [patient] states [s/he] was sitting in their urine for over 2 hours, unable to get a hold of staff for help. This is the second call patient has made in the past week.</p> <p>Further review contained an admission MDS assessment for Resident #4 that recorded that Resident #4 was frequently to always incontinent with bowel and bladder and totally depended on facility staff for incontinence care (Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs).</p> <p>A continued review was done of geriatric nurse aides' (GNAs) ADL (activity of daily living) documentation of incontinence care provided to Resident #4 from August 28 to September 5, 2025.</p> <p>The review lacked documentation of assistance with incontinence care for Resident #4 during the morning shift on 8/30/25, the evening and night shifts on 8/31/25, and the evening shift on 9/1/25.</p> <p>In an interview on 10/20/2025 at 12:42 PM, the interim Director of Nursing (DON) confirmed the lack of documentation showing that Resident #4 received incontinence care during the shifts identified in the earlier review and verbalized understanding of the concerns.</p> <p>2) Review of the facility's investigation of Incident #2596621 on 10/21/2025 at 7:12 AM noted that Resident #5's representative verbalized concerns of the Resident's shower schedule not being followed.</p> <p>The continued review of an MDS assessment for Resident #5, dated 8/15/25, showed that the Resident's diagnosis included Dementia, had severe cognitive impairment, and required substantial/maximal assistance from staff for completing his/her self-care needs, including showers.</p> <p>A review of the shower schedule for the Longmeadow Unit showed that Resident #5 was scheduled to receive two showers per week, on Tuesdays and Fridays, for a total of 8 showers per month.</p> <p>Further review of the GNA ADL documentation for Resident #5's showers from July 1 to October 21, 2025, was completed. The review showed one shower on 7/22/25, one on 8/3/25, one on 9/1/25, and one on 10/14/25.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/21/2025, at 10:39 AM, staff #3, a GNA, checked the facility's electronic health record (EHR) and reported that Resident #5's showers were not scheduled.</p> <p>During an interview on 10/21/2025 at 11:44 AM, the DON stated that the facility had identified an issue in which the paper shower schedules on the units did not match the shower schedules in the EHR. However, after the surveyor's intervention, staff #3 made her aware that the problem still existed.</p> <p>The DON added that there was no additional evidence that Resident #5 received his/her showers on the other days in July, August, September, and October.</p> <p>3) A review of Resident #8's clinical record revealed that he/she had fallen at home, been hospitalized with serious medical concerns and was then transferred to the facility on 9/05/25 for rehabilitation and nursing care.</p> <p>On 10/20/25 at 8:30 AM a review of complaint #2640271 revealed an allegation that the facility failed to provide personal care to Resident #8 on more than one occasion. On 10/20/25 at 11:19 AM, in a telephone interview with the complainant, they reaffirmed the concerns.</p> <p>On 10/20/21 at 2:26 PM a review of the Geriatric Nursing Assistant (GNA) care documentation for Resident #8 revealed multiple shifts with blanks where no care was documented. On 9/05/25 the spaces to document care was blank for two of three shifts for personal hygiene, eating, dressing and toileting hygiene.</p> <p>On 10/21/25 at 8:05 AM an interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to review the concern that a complainant alleged the facility failed to provide personal care to Resident #8, and that the clinical record lacked documentation that care was provided.</p> <p>When the DON was asked what would be documented if a resident refused care, she said the record would have an entry that reflected that. When asked if no entry &amp;ndash; a blank space- meant that the resident did not get care she said she did not know for sure. When asked how the DON ensured that residents received ADL care she said that she did rounds, and the night supervisor, and charge nurses also made rounds. She also said she reviewed documentation for completeness and followed up with employees when deficiencies were found. She said she was unaware of Resident #8's lack of documentation.</p> <p>On 10/21/25 at 11:43 AM an interview was conducted with the NHA to review the finding that the facility failed to provide personal care to Resident #8. She acknowledged the finding and provided no further evidence prior to the end of the survey.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interview it was determined that the facility failed to ensure that resident records were accurate and complete. This was evident for 1 resident (Resident #8) of 2 residents reviewed for neglect. The findings include: On 10/20/25 at 8:30 AM a review of Resident #8's clinical record revealed that the resident was transferred to the hospital on 9/10/25 due to shortness of breath. On 10/21/25 at 10:04 AM an interview was conducted with the Director of Nursing (DON). When asked about treatment for the resident's shortness of breath, the DON explained that the resident experienced a change in condition on 9/09/25 and that Resident #8's on call provider gave new orders for oxygen and other treatments. The DON provided a copy of a document dated 9/09/25, titled Change in Condition, written by Licensed Practical Nurse (Staff #4). It noted that PRN [as needed] O2 [oxygen] 2L [at two liters/minute]. Further review of the record failed to reveal any physician's order for the oxygen use. On 10/21/25 at 11:43 AM the DON was interviewed again and she confirmed that no order for oxygen was entered into Resident #8's medical record.</p>		