STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395348	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chambersburg Skilled Nursing and Rehabilitation Ce	1070 Stouffer Avenue Chambersburg, PA 17201

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, facility documentation review, and staff interviews, it was determined that the facility failed to ensure residents were free from resident to resident abuse by a resident with a history of abuse (Resident 1). This resulted in actual physical harm by Resident 1, as evidenced by multiple skin tears and bruising of a resident (Resident 2). Effective interventions were not put into place to protect residents from physical and psychosocial abuse. This failure resulted in an Immediate Jeopardy situation.Findings include: Facility policy, titled Abuse Prohibition, revised November 15, 2025, read in part, 5. Actions to prevent abuse.will include: 5.2 identifying, correcting, and interviewing in situations in which abuse.is more likely to occur. 6. Staff will identify events - such as suspicious bruising, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation. This also includes patient-to-patient abuse. 6.3.1 The Center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included Alzheimer's disease (progressive brain disease that destroys memory and thinking skills) and intermittent explosive disorder (repeated sudden bouts of impulsive, aggressive violent behavior). Review of Resident 1's progress notes revealed that on March 28, 2026, staff documented that Resident 1 punched another resident on the head. Review of the facility's provided incident report dated March 28, 2026, at 2:15 PM, revealed that Resident 1 punched Resident 3 on top of the head with his fist. Resident 1 was placed on 1:1 supervision and Resident 3 was transferred to the emergency department for further evaluation. In a written statement dated March 28, 2026, Employee 1, Nurse Aide (Nurse Aide [NA]) stated Resident 3 was sitting in the hallway and shouted something to Resident 1. Resident 1 responded by punching Resident 3 in the head. Clinical record review revealed that Resident 3 had diagnoses that included Alzheimer's disease, osteoporosis (brittle bones), and generalized anxiety disorder (persistent, excessive, and uncontrollable worry about everyday events). Review of Resident 3's care plan revealed that Resident 3 had a history of trauma with an intervention for no male staff in her room. On March 31, 2026, Resident 1 was evaluated by psychological service and removed from 1:1 supervision due to not displaying behavioral concerns. Further review of Resident 1's care plan revealed no behavior care plan was developed and no interventions were added. On April 27, 2026, at 11:15 AM, staff documented Resident 1 in the hallway sitting on a bench and became agitated and yelling out using several profanities. Resident 1 then walked over to the nurses' station and kicked the door threatening to hit the staff member. Resident 1 was walked down the hall by staff to attempt to redirect. Resident 1 then stated that I just need to kill everyone at this point. Resident 1 was seen recently by psychological services and Seroquel (antipsychotic medication) was recently increased to twice a day due to agitation. An order was obtained to send Resident 1 to hospital for further evaluation. On April 29, 2026, at 8:59 AM, staff documented that Resident 1 was pacing the hallways, pulling at the doors, cursing and threatening staff. A staff member approached Resident 1 to attempt to redirect the Resident and Resident 1 tried hitting her. When staff asked Resident 1 what he was upset about the Resident stated, you f***ing (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	people won't let me out. Several attempts were made to redirect Resident 1 but were unsuccessful. The provider was notified of Resident 1's behaviors and an order was obtained for Hydroxyzine (medication used to treat anxiety and tension caused by nervous or emotional conditions) 25 milligrams (mg) every 12 hours as needed (PRN). Review of Resident 1's medication administration record for April 2026 and May 2026 revealed that Hydroxyzine 25 mg every 12 hours PRN was ordered for 14 days. Resident 1 received the medication on April 29 and May 5 and 11, and documented as effective. The Hydroxyzine was discontinued on May 14, 2026 and not reordered. On May 21, 2026, at 6:54 PM, staff documented that Resident 1 was verbally aggressive when asked to leave another resident's room, and that Resident 1 kicked the door and attempted to put his hands around another staff member's neck. Review of Resident 1's care plan revealed that a behavior care plan had still not been developed. On May 22, 2026, at 7:17 PM, a transfer note indicated that Resident 1 was transferred to the hospital for behavioral symptoms. Further review of Resident 1's progress notes revealed no additional notes indicating what symptoms Resident 1 was experiencing. Review of a facility provided incident report dated May 22, 2026, revealed that at 5:30 PM, staff in the dining room heard Resident 1 say G*d d**n b***h, and heard a female resident yell. Staff observed Resident 1 with his arms straight out in front of him and Resident 5 sitting on the floor in front of Resident 1. Due to a wall obstructing staff's view, they were not able to see if Resident 1 had made contact with Resident 5. Resident 5 was not able to communicate what had happened. No injuries were noted for either resident. Resident 1 was placed on 15 minute checks. An additional incident report dated May 22, 2026, revealed that at 7:00 PM, staff observed Resident 1 hit Resident 3 on the head with an open hand, and that Resident 1 was transferred to the hospital for evaluation. Review of Resident 1's progress notes revealed that Resident 1 returned from the hospital at 11:00 PM with no new orders and that 15 minute checks would be continued. Review of Resident 1's care plan revealed it was updated to include a care area that Resident 1 exhibits or has the potential to exhibit physical and sexual behaviors related to cognitive loss/dementia, initiated on May 22, 2026, with an intervention to encourage away from female residents when agitated and 15 minute checks. On May 26, 2026, at 1:25 PM, staff noted that Resident 1 was verbally aggressive with staff when redirected out of another resident's room. On May 26, 2026, at 3:04 PM, Resident 1 was seen by the medical doctor and 15 minute checks were discontinued. On May 27, 2026, at 2:54 PM, staff noted that they heard a woman scream from the parlor (Resident 4) and observed Resident 1 coming out of the parlor cursing. Upon entering the parlor, the Resident 4 reported that Resident 1 hit her on the arm and she asked him to stop coming into her room. Review of a facility provided incident report dated May 27, 2026, at 2:30 PM, revealed Resident 4 reported that Resident 1 hit her on the arm. The incident was not witnessed and no injuries were noted for either resident. Resident 1 was placed on 1:1 supervision. Review of Resident 1's care plan revealed that Resident 1's care plan was updated to include that Resident 1 was at risk or experiencing emotional distress related to past trauma, as evidenced by changes in mood, anxiety, agitation, aggression, sleep disturbance, and difficulty coping with daily stressors, initiated May 29, 2026; and interventions were added for 1:1 related to agitation, aggression as need, initiated on May 28, 2026 and resolved on June 4, 2026. On June 1, 2026, at 6:59 PM, staff noted that Resident 1 was walking in the hallway while being monitored 1:1 by a NA. Resident 1 passed by another female resident (Resident 3) that was sitting by the door to her room. The female resident told Resident 1 not to come close to her room. Resident 1 became verbally aggressive towards the female resident and hit her on the arm. Review of a facility provided incident report dated June 1, 2026, at 4:35 PM, revealed that Resident 1 hit Resident 3 on the arm after Resident 3 told him to stay away from her room. 1:1 supervision was in place at the time of the incident. No injuries were noted for either resident. Review of Resident 1's care plan revealed no updated interventions. On June 4, 2026, at 1:06 PM, Resident 1 was evaluated by psychological services and removed from 1:1 supervision due to not displaying behavior concerns. On June 4, 2026, at 6:17 PM, staff noted that Resident 1 was verbally aggressive to another resident he passed in the hallway and to staff when (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they intervened. On June 8, 2026, at 12:41 AM, staff noted that they entered Resident 1's room and observed Resident 1 standing over his roommate (Resident 2), kicking and screaming at the roommate. The staff removed Resident 1 from the room and returned to help the roommate. Staff then heard a scream down the hall and found that Resident 1 had slapped another resident (Resident 7) in the face. Review of Resident 2's clinical record revealed diagnoses that included aphasia (communication disorder affecting the ability to speak) following cerebral infarction (blood supply to part of the brain is blocked or reduced causing damage) and mild cognitive impairment (slight decline in memory or thinking). Review of a facility provided incident report dated June 8, 2026, at 12:40 AM, revealed that staff entered the room and observed Resident 2 on the floor and Resident 1 kicking him. Resident 2 responded yes when asked if Resident 1 had pulled him out of bed. Resident 2 had skin tears to his left arm, right cheek, and right arm, abrasions to his scalp, bruising and abrasion to his left knee, and multiple bruises to the left leg. Resident 2 was transferred to the hospital for further treatment. Review of a facility provided incident report dated June 8, 2026, at 12:46 AM, revealed that staff heard a resident scream and found Resident 7 sitting at the nurse's station holding the left side of her face. Resident 7 pointed at Resident 1 and stated that Resident 1 hit her. No injuries were noted for either resident. Resident 1 was transferred to the hospital for evaluation. Review of Resident 1's care plan revealed no updated interventions. An interview with the Director of Nursing (DON) on June 17, 2026, at approximately 11:31 AM, revealed that Resident 1 was being followed by psychiatric services and that multiple medication changes had been made since admission to the facility in attempts to regulate his mood. They had attempted numerous nonpharmacological interventions as well including buying him a guitar, moving him to a private room, and keeping him separated from residents he had altercations with. Social services had also attempted to contact other facilities but they either had no beds available or didn't call back. Review of Resident 1's clinical record revealed that PRN medication for behaviors was discontinued on May 14, 2026, and nothing new was ordered. The clinical record failed to include evidence that nonpharmacological interventions were put into place or that music therapy was used when the Resident was exhibiting behaviors. Observations made on June 17, 2026, at 12:20 PM, revealed Resident 1 sitting in the dining room at a table with Resident 2 and Resident 3, both were Residents that Resident 1 had previously assaulted. Resident 1's 1:1 staff was sitting to his left but not between him and the other residents. Upon exiting the dining room, Resident 1's 1:1 staff exited the room ahead of Resident 1. On June 17, 2026, at 2:42 PM, the DON was notified that the facility failed to put effective interventions in place for Resident 1 to ensure the safety of other residents and prevent physical and psychological abuse, which constituted an Immediate Jeopardy situation. The Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. On June 17, 2026 at 7:10 PM the facility's immediate action plan was accepted, which included the following:A full abuse investigation will occur within the facility with staff, residents and families of those who are unable to speak for themselves; to ensure no other residents have witnessed abuse or been abused.If any further potential abuse is brought forward, the facility will immediately remove the resident from the situation, ensure they are safe and comfortable, and potential interventions will be reviewed with a provider and put into place as indicated.A quiz will be given to all staff members after education to ensure the abuse process is retained. The quiz will include who the staff notifies upon alleged abuse identification (the abuse coordinator or DON), and when they notify (immediately).A full center behavior audit will occur to ensure all resident with current behaviors have been identified with interventions in place. If an intervention is not in place or not effective, psych and provider will be notified, change in condition will be documented and interventions will be reviewed and adjusted as indicated.An audit of current residents' skin will occur to ensure that there are no unidentified signs of injury or abuse. If any concerns are noted, the change in condition process will be followed and notifications to the provider, family and abuse coordinator will occur to ensure monitoring occurs. A report to the state agency will occur as necessary.Audits will be completed for the 1:1 documentation (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for completeness.Care plan will be updated to include Resident 1 will not be seated near resident that were assaulted and he will be kept within a safe distance from the residents that were assaulted.Findings will be taken to QAPI. On June 18, 2026, at 11:48 AM, the Immediate Jeopardy was lifted during the onsite survey after ensuring that the immediate action plan had been implemented. The facility failed to prevent resident to resident abuse. Resident 1 assaulted Resident 3 on March 28, 2026; May 22, 2026; and June 1, 2026. Resident 1 also assaulted Resident 4 on May 27, 2026, and Resident 5 on May 22, 2026. On June 8, 2026, Resident 1 pulled Resident 2 out of bed and was kicking and hitting him, resulting in multiple skin tears and bruising. Resident 1 was separated from Resident 2 and then walked down the hall and hit Resident 7. The facility did not have effective interventions in place to protect residents from physical and psychosocial abuse from Resident 1. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing services