STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395440	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camp Hill Skilled Nursing and Rehabilitation Ctr	1700 Market Street Camp Hill, PA 17011

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Actual harm Residents Affected - Few	Based on facility policy review, clinical record review, facility documentation review, and staff interview, it was determined the facility failed to ensure each resident was free from neglect, which resulted in actual harm as evidenced by fracture of the right hip for one of three residents reviewed (Resident 1).Review of facility policy, titled OPS 300 Abuse Prohibition with a last revision date of October 24, 2022, revealed Neglect is defined as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of Resident 1's clinical record revealed diagnoses that included history of cerebral infarction (also known as stroke or cerebral vascular accident - sudden loss of blood flow or bleeding into the brain that causes brain cell death), right- above the knee amputation and diabetes mellitus type II (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).Review of Resident 1's comprehensive plan of care revealed a care plan with a focus of, ADL [Activities of Daily Living] self care deficit as evidenced by generalized weakness related to physical limitations, history of [cerebral vascular accident], which was last revised August 23, 2024. Review of Resident 1's ADL care plan revealed the intervention of, ADL Assist: Assist of two [staff members] with ADL's, which was last revised on April 17, 2024.Review of Resident 1's Kardex (quick reference tool utilized to identify a resident's care needs/preferences and assistance needed) revealed section titled, Dressing/Grooming/Bathing, which stated, ADL Assist of two with ADL's.Review of facility incident report dated October 16, 2025, revealed Resident 1 sustained a witnessed fall from bed at 11:45 AM. Review of the Incident Description, revealed it stated, During brief change [Resident 1] was holding on the [sic] arm of the chair next to bed and the chair moved and [Resident 1] kept rolling off the bed and was lowered to the floor by CNA [Employee 1 - Nurse Aide]. Review of Resident 1's interdisciplinary progress notes revealed that an assessment conducted by the Registered Nurse revealed Resident 1 had pain in the right hip, left knee and ankle, and that an x-ray of the area had been ordered.Review of X-ray results dated October 16, 2025, revealed Resident 1 suffered a right-sided acute intertrochanteric fracture (hip fracture). Resident 1 was subsequently sent to the hospital emergency room for evaluation and treatment. Resident 1 was considered for surgery; however, found not to be a candidate for surgery due to health conditions.Review of a witness statement by Employee 1 dated October 16, 2025, revealed Employee 1 stated, I did not know that [Resident 1] needed 2 people until after the incident. I did check her Kardex and did not see where it said 2 assist for toileting. I was providing incontinence care, I was not aware that incontinence care is considered an ADL. Review of the Care Plan and Kardex for Resident 1 revealed that the only assist level noted during the time of the fall was for a two person assist. Review of Employee 1's facility education revealed that Employee 1 completed the following education modules: Bed safety on October 9, 2025. Abuse & Neglect OTS on September 5, 2025. 2025 Q3 Mandatory Safe Resident Handling Training - Clinical Employees, on July 3, 2025. Safe Resident Handling: Active Transfers and Mobility - Clinical Staff, on July 3, 2025. SQ LTC: Falls, Assessment and Prevention, on July 3, 2025. Patient Rights and abuse & Neglect Prevention, on June 20, 2025. SQ LTC: Abuse and Neglect, on April 6, 2025. SQ LTC: Patient or Resident Safety Basics, Patient-Facing, on April 6, 2025.Employee 1 failed to follow the plan of care for Resident 1 and proved incontinence care independently, instead of with a second employee, which resulted in Resident 1 falling from her bed and sustaining a right hip fracture.During staff interview with the Nursing Home Administrator (NHA) on October 23, 2025, at approximately 11:45 AM, he confirmed that Employee 1 neglected to follow the plan of care for Resident 1 by failing to provide ADL care with two staff, which resulted in Resident 1 falling from the bed and sustaining a fracture of the right hip, requiring a transfer to the hospital. During the staff interview, the NHA confirmed that Employee 1 was terminated from her position as a result of the facility investigation.28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1)(e)(1) Management28 Pa. Code 201.29 (a) Resident rights28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services

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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. Based on facility policy review, clinical record review, select facility document review, facility training records, and staff interview, it was determined that the facility failed to ensure that residents received adequate assistance to prevent falls, which resulted in harm as evidenced by a fracture of the right hip for one of three residents reviewed for falls (Resident 1).Review of facility policy titled, NSG200 Activities of Daily Living (ADLs), last revised May 1, 2023, revealed Activities of Daily Living (ADLs) were defined as, Hygiene - bathing, dressing, grooming, and oral care;.Elimination - toileting. Review of the policy purpose revealed it stated, To ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences.Review of Resident 1's clinical record revealed diagnoses that included history of cerebral infarction (also known as stroke or cerebral vascular accident - sudden loss of blood flow or bleeding into the brain that causes brain cell death) above the knee amputation of the right leg and diabetes mellitus type II (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).Review of Resident 1's comprehensive plan of care revealed a care plan with a focus of, ADL self care deficit as evidenced by generalized weakness related to physical limitations, history of [cerebral vascular accident], which was last revised August 23, 2024. Review of Resident 1's ADL care plan revealed the intervention of, ADL Assist: Assist of two [staff members] with ADL's, which was last revised on April 17, 2024.Review of Resident 1's Kardex (quick reference tool utilized to identify a resident's care needs/preferences and assistance needed) revealed section titled, Dressing/Grooming/Bathing, which stated, ADL Assist of two with ADL's.Review of facility incident report dated October 16, 2025, revealed Resident 1 sustained a witnessed fall from bed at 11:45 AM. Review of the Incident Description, revealed it stated, During brief change [Resident 1] was holding on the [sic] arm of the chair next to bed and the chair moved and [Resident 1] kept rolling off the bed and was lowered to the floor by CNA [Employee 1 - Nurse Aide]. Review of Resident 1's interdisciplinary progress notes revealed that an assessment conducted by the Registered Nurse revealed Resident 1 had pain in the right hip, left knee and ankle, and that an x-ray of the area had been ordered.Review of x-ray results dated October 16, 2025, revealed Resident 1 suffered a right-sided acute intertrochanteric fracture (hip fracture). Resident 1 was subsequently sent to the hospital emergency room for evaluation and treatment. Resident 1 was deemed not appropriate for surgical intervention due to multiple health factors.Review of a witness statement by Employee 1, dated October 16, 2025, revealed Employee 1 stated, I did not know that [Resident 1] needed 2 people until after the incident. I did check her Kardex and did not see where it said 2 assist for toileting. I was providing incontinence care, I was not aware that incontinence care is considered an ADL.Review of the Care Plan and Kardex for Resident 1 revealed that the only assist level noted during the time of the fall was for a two person assist.Employee 1 failed to ensure Resident 1 was free from accident hazards by performing incontinence care independently, instead of with a second employee per Resident 1's plan of care, which resulted in Resident 1 falling from her bed and sustaining a right hip fracture.During an interview with the Nursing Home Administrator (NHA) on October 23, 2025, at approximately 11:45 AM, he revealed it was his expectation that facility nursing staff should know that incontinence care is considered an activity of daily living. Further, the NHA revealed that he expected facility staff to follow residents' plans of care.201.4(a) Responsibility of licensee201.18(b)(1)(e)(1) Management211.10(c)(d) Resident care policies211.12(d)(1)(2)(5) Nursing services