

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/13/2026
NAME OF PROVIDER OR SUPPLIER  Laurel Lakes Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  201 Franklin Farm Lane 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 0755  Level of Harm - Actual harm  Residents Affected - Few	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on facility policy review, clinical record review, review of facility documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide pharmaceutical services to meet the needs of each resident for three of seven residents reviewed (Resident 1, 4, and 7), which resulted in actual harm as evidenced by a right elbow fracture and laceration for one of seven residents reviewed (Resident 1). Findings Include: Review of facility policy, titled Pharmscript Provider Pharmacy Requirements, last revised August 2020, read, in part, Procedures: 4. f. Providing routine and timely pharmacy service as contracted, as well as emergency pharmacy service 24 hours per day, seven days per week. New medication orders are available for administration on the next routine delivery, unless otherwise requested by facility staff. Medication will be delivered by the primary pharmacy or back-up pharmacy or are available from the emergency medication kit/back-up medication supply. Review of Resident 1's clinical record revealed diagnoses that included epilepsy (brain disorder causing reoccurring seizures), type two diabetes mellitus (body cannot use insulin correctly causing high blood sugar), and sepsis (body's extreme response to an infection causing organ damage). Review of Resident 1's nursing progress notes revealed Resident 1 was admitted to the facility from the hospital on December 24, 2025, at approximately 2:40 PM. Review of Resident 1's physician orders at the time of admission revealed the following orders: Carbamazepine extended release 200 milligrams (mg), two tablets one time a day related to epilepsy. Carbamazepine extended release 200 mg, three tablets at bedtime related to epilepsy. Doxycycline Hyclate 100 mg, one capsule two times a day related to cutaneous abscess of back. Duloxetine HCL delayed release 60 mg, one capsule one time a day for depression. Finasteride 5mg, give one tablet one time a day for bph. Metoprolol Succinate extended release 25 mg, one tablet one time a day related to essential hypertension. Phenobarbital 100 mg, one tablet two times a day related to epilepsy. Pregabalin 100 mg, one capsule two times a day related to neuropathy. Rosuvastatin Calcium 40 mg, one tablet one time a day related to hyperlipidemia. Review of Resident 1's medication administration record (MAR) for December 2025 revealed on December 24, 2025, Resident 1's 7:00 PM doses of Carbamazepine and Doxycycline were marked 9 and on December 25, 2025; and Resident 1's 7:00 AM doses of Carbamazepine, Doxycycline, Finasteride, Metoprolol, Phenobarbital, Pregabalin, and Rosuvastatin were marked 9. Review of the MAR key code revealed 9 = other/see nursing notes. Further review of Resident 1's nursing progress notes revealed notes corresponding with the aforementioned dates, times, and medications stating that the medications were not available. Review of Resident 1's clinical record indicated he missed one dose of his antiseizure medication (Carbamazepine) on December 24, 2025, and two doses of his antiseizure medications (Carbamazepine and Phenobarbital) on December 25, 2025. Additional review of Resident 1's nursing progress notes revealed that on December 25, 2025, at 3:21 PM, Resident 1 was found lying on the floor next to his bed, unresponsive with seizure like activity and a moderate amount of blood was noted on Resident 1's forehead. The episode was noted as lasting</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
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F 0755  Level of Harm - Actual harm  Residents Affected - Few	<p>approximately five minutes and Resident 1 was lethargic (decrease in consciousness) and postictal (recovery period following a seizure) following the episode. EMS was called and Resident 1 was transported to the hospital. Review of Resident 1's hospital summary dated December 25, 2025, at 7:49 PM, revealed that Resident 1 was initially treated in the emergency department for seizure activity and a head laceration, and was subsequently admitted to the hospital for observation. X-ray results revealed that Resident 1 suffered a mildly displaced fracture of the right radial head. Review of the emergency room physician's notes revealed that Resident 1 was alert and oriented at the time of the evaluation and reported he had seizures all of his life, and that he was very well controlled with medication. His last seizure was in the 1990s. He reported that the facility did not have his seizure medications in stock and were unable to administer them. During an interview on January 13, 2026, at approximately 2:00 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON) it was revealed that the contracted pharmacy delivers to the facility twice a day and a local pharmacy can be used as a backup for emergent medications. The contracted pharmacy determines the need for the use of the backup pharmacy and sends the orders to them. The facility is not sure where a breakdown in communication occurred but stated they did identify the issue after the incident with Resident 1. Review of Resident 4's clinical record revealed diagnoses that included type two diabetes mellitus, epilepsy, and sepsis (body's extreme response to an infection causing organ damage). Review of Resident 4's nursing progress notes revealed Resident 4 was admitted to the facility from the hospital on December 23, 2025, at approximately 8:40 PM. Review of Resident 4's physician orders at the time of admission revealed the following orders: Divalproex Sodium delayed release 500 mg tablet, 1 tablet two times per day for seizures. Glipizide 5 mg tablet, 1.5 tablets one time a day for diabetes mellitus. Levetiracetam 500 mg tablet, 1 tablet three times a day for seizures. Memantine HCL 5 mg tablet, 1 tablet two times a day for dementia. Movantik 25 mg tablet, 1 time a day for GERD. Unisom sleep tabs 25 mg, 1 tablet at bedtime for insomnia. Review of Resident 4's MAR for December 2025 revealed that on December 23, 2025, Resident 4's 8:00 PM dose of Unisom and 9:00 PM dose of Divalproex Sodium were left blank. On December 24, 2025 Resident 4's 7:00 AM doses of Divalproex, Glipizide, Levetiracetam, Movantik, Memantine; 1:00 PM dose of Levetiracetam; 8:00 PM doses of Levetiracetam and Unisom, and 9:00 PM dose of Memantine were marked 9. On December 25, 2025 Resident 4's 7:00 AM doses of Glipizide, Movantik, and Memantine and 8:00 PM dose of Unisom were marked 9. On December 26, 2025 Resident 4's 8:00 PM dose of Unisom was marked 9. Review of the MAR key code revealed 9 = other/see nursing notes. Further review of Resident 4's nursing progress notes revealed notes corresponding with the aforementioned dates, times, and medications stating that the medications were not available. Review of Resident 7's clinical record revealed diagnoses that included epilepsy and major depressive disorder (persistently low or depressed mood). Review of Resident 7's nursing progress notes revealed Resident 7 was admitted to the facility from the hospital on December 1, 2025, at approximately 1:43 PM. Review of Resident 7's physician orders at the time of admission revealed the following orders: Imipramine HCL 10 mg tablet, 1 tablet at bedtime related to essential hypertension. Lamotrigine 100 mg tablet, 1 tablet every morning and at bedtime related to epilepsy. Topiramate 200 mg tablet, 1 tablet every morning and at bedtime related to epilepsy. Review of Resident 7's MAR for December 2025 revealed that on December 1, 2025, Resident 7's 8:00 PM doses of Imipramine HCL, Lamotrigine, and Topiramate were marked 9. On December 2, 2025 Resident 7's 8:00 AM dose of Topiramate and 8:00 PM dose of Imipramine HCL were marked 9. Review of the MAR key code revealed 9 = other/see nursing notes. Further review of Resident 7's nursing progress notes revealed notes corresponding with the aforementioned dates, times, and medications stating that the medications were not available. During an interview on January 13,</p> <p>(continued on next page)</p>		

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F 0755  Level of Harm - Actual harm  Residents Affected - Few	<p>2026 at approximately 2:00 PM, the NHA stated that the facility identified the noncompliance and a plan of correction was developed and initiated. The facility has been working with the contracted pharmacy and the local hospitals. The new plan is that prior to admission to the facility the DON will coordinate with the hospital and the contracted pharmacy to initiate the resident's medications. When residents are discharged from the hospital late in the day, the hospital will either administer their medications or discharge them with one to two doses of the medication. If the hospital is unable to provide the medication, the local backup pharmacy will dispense one to two doses until the contracted pharmacy can deliver the medication. Audits were initiated and are ongoing. The DON also reviewed and updated the medications available in the facility's Omnicell (an automated secure medication dispensing system). The incident with Resident 1 and the facility's plan of correction were reviewed at a QAPI meeting on December 29, 2025. The facility's plan of correction was reviewed during an onsite survey on January 13, 2026. Audits were performed on all new admissions to ensure timely administration of medications. Audits were initiated on December 28, 2025, and are ongoing. The facility's Omnicell medication stock has been updated. Education for all licensed staff was initiated on December 26, 2025, and completed on January 2, 2026. Education was reviewed and included education on communication with pharmacy, pharmacy hours/holiday schedules, utilizing the backup pharmacy, updated medications available in the Omnicell, and the facility's updated policy titled, Pharmacy Deliveries and Medication Escalation Policy, effective December 26, 2025. Review of facility plan of correction documentation revealed that on January 2, 2026, the facility had completed audits and education for staff to ensure compliance with pharmacy services. During the abbreviated survey, audits and staff education were reviewed. Staff interviews, resident record review, and observations revealed no concerns with pharmacy services. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		