

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  07/31/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on review of facility policy, review of grievances, and interviews with staff and residents, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 34 residents reviewed (Resident 130). Findings include: Review of the facility policy, titled Dignity, with a last reviewed and revised date of February 2021, revealed, Each resident shall be cared for in a manner promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Review of Resident 130's clinical record revealed diagnoses of morbid obesity (a body mass greater than 40) and acute respiratory failure (when lungs cannot adequately exchange gases, leading to insufficient oxygen in the blood). Interview with Resident 130 on August 28, 2025, at 1:15 PM, revealed that Resident 130 had filed a complaint in June 2025, with the facility after Employee 1 had helped Resident 130 clean up and used disposable paper towels to dry Resident 130 because she said that she didn't have any bath towels. Review of facility provided grievance/concern form, dated June 5, 2025, revealed a complaint filed by Resident 130 that, during her daily care, she was dried off with paper towels. Further review revealed that there were bath towels available, but Employee 1 did not leave the unit to look for them. The resolution of this grievance was that Employee 1 was educated on going to other units to get supplies if they are not available where they are. Interview with Director of Nursing on April 31, 2025, at 11:35 AM, revealed that she would expect staff members to treat residents with dignity and respect. 28 Pa. Code 211.12(d)(1)(5) Nursing services</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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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and staff interviews, it was determined that the facility failed to convey resident's funds within 30 days, and a final accounting of those funds to the resident upon discharge for one of three resident closed records reviewed (Resident 179). Findings include: Clinical record review revealed Resident 179 was admitted to the facility on [DATE], discharged from the facility on February 27, 2025, and did not return. Review of Resident 179's final billing statement revealed she had a credit of \$638.00 that was issued in the form of a check on May 30, 2025. Interview with Employee 4 (Business Office Manager) on July 30, 2025, at 1:40 PM, revealed the transaction history report for Resident 179 indicated that she was issued a refund check on May 30, 2025, and that a third party billing system messed up transaction so she had to reverse it, but the process for issuing resident refunds typically would occur within 30 days. During an interview with the Director of Nursing on July 31, 2025, at 12:39 PM, she revealed she had no further information to provide as to why Resident 179's refund was issued late, and she would expect refunds to be issued within 30 days. 28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, resident and staff interviews, and facility documentation review, it was determined that the facility failed to provide comfortable temperatures on two of five nursing units (E and F) and failed to provide a clean homelike environment in one of 34 rooms observed (Resident 3).</p> <p>Findings include:</p> <p>Observation on July 28, 2025, the facility had two additional portable air conditioner (AC) units running in the main lobby and at the end of E and F nursing units.</p> <p>On July 29, 2025, between 10:00 AM and 11:00 AM, during the screening process with Residents 101, 141, 168, and 172, who share a room, the Residents stated that it was very warm in their room. The surveyor agreed that the temperature of the room felt very warm. Employee 10 (Director of Maintenance) was notified to obtain the temperature of the room, which was 83.6 degrees Fahrenheit (F).</p> <p>During an interview with Employee 10 on July 29, 2025, he stated that he would place a portable floor air conditioner in Residents' 101, 141, 168, and 172 room. Employee 10 was asked if the HVAC (Heating Ventilation Air Condition) system is working properly, and he replied "yes." Outdoor temperature for the area was 93 degrees F at noon and 93 degrees F at 6:00 PM on July 29, 2025.</p> <p>A review of logged temperatures for all units obtained for July 14 through 25, 2025, revealed temperatures in the 60's and 70's within the facility.</p> <p>Additional temperature recordings on the F Hall revealed three additional rooms were recorded as 82.4, 84.4, and 82.4-degrees F. Maintenance installed portable AC units in each of these rooms. Resident 51 was the only Resident in these rooms who stated she was warm when residents were asked if they were asked about the temperature of the room.</p> <p>On July 29, 2025, at approximately 3:10 PM, Resident 9 approached a surveyor in the front lobby and stated that she did not feel well because of the heat. The surveyor reported immediately to Administration so that they could assess Resident 51. Resident 51's vital signs were stable, and her temporal temperature was 96.8 F.</p> <p>A review of the Resident 9's progress notes stated that she was on a leave from the facility on this day with family from 9:50 AM until 1:00 PM. The facility added an additional portable AC unit to Resident 9's room. Resident 9's room temperature was recorded to be 79 degrees F on July 29, 2025, at 2:15 PM.</p> <p>On July 30, 2025, at approximately 9:30 AM, the Director of Nursing (DON) informed the surveyor that during the evening of July 29, 2025, temperature of the E-F dining room was 83 F and later climbed to 87 F.</p> <p>On July 30, 2025, the E-F dining room was closed to residents to install a split AC unit. The facility had already purchased the unit (receipt dated July 1, 2025) and it was on maintenance work plan, but with the increase in outside and inside temperatures it became a priority.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Resident 9 on July 30, 2025, at approximately 11:45 AM, Resident 9 said that she is feeling great and added that she doesn't tolerate heat very well and was happy to have the portable AC installed in her room. The Resident was observed multiple times ambulating throughout the facility and had no complaints about the temperature. Resident 9's room temp was 75.4 degrees F on July 30, 2025, at 9:45 AM.</p> <p>The facility continued to monitor temperatures of residents and resident rooms through the evening of July 29 to AM of July 30, 2025.</p> <p>On July 30, 2025, at 9:45 AM, the room temperatures were taken again, one room was 83.6 degrees F, that previously was 80 degrees F during the prior recording. A portable AC unit was placed in the room. No complaints by Residents in the room.</p> <p>On July 30, 2025, from 9:40 AM through 10:05 PM, all other room temperatures were 74.8 -79.4 F, no complaints by residents, many observed with sweaters on and covered with blankets or sheets while lying in bed.</p> <p>During an interview with the DON on July 31, 2025, the DON confirmed that temperatures are to remain within 71-81 degrees F for the comfort of residents.</p> <p>Observations in Resident 3's room on July 28, 2025, at 11:52 AM; July 29, 2025, at 2:00 PM; and on July 30, 2025, at 12:25 PM, revealed a black pedestal fan that was positioned at the head of Resident 3's bed that was running and was noted to have a moderate amount of gray fuzz on the front and back casing as well as on the blades.</p> <p>During a staff interview with the DON on July 31, 2025, at 1:50 PM, she confirmed that the fan should have been on a cleaning schedule.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on policy review, facility documentation review, as well as resident and staff interviews, it was determined that the facility failed to ensure that a timely response was provided to a resident following submission of a grievance for one of two residents reviewed for grievances (Resident 168). Findings include: Review of facility policy, Grievance Process Procedure, dated October 2021, revealed, Upon the completion of the facility investigation, the administrator will ensure that the investigation results and resolution steps are communicated to the individual who originally submitted the grievance, complaint and/or suggestion. Resolution of the concern is desired within five (5) working days from the date the concern was filed. Routine follow up on concerns that are outstanding will be completed through the morning meeting process. During an interview with Resident 168 on July 29, 2025, at 11:05 AM, she revealed that she submitted a grievance regarding food concerns about a month ago, but never heard a thing about it. Review of a grievance form dated July 4, 2025, revealed that Resident 168 filed a grievance on that date regarding not being served her meal timely and at an appropriate temperature. Further review of the form revealed that the concern was marked as resolved, and the form was signed by the dietary manager and grievance officer. However, the portion of the form used to document the method and date for notifying the Resident of the resolution was blank. During an interview with the Director of Nursing on July 31, 2025, at 12:25 PM, she confirmed that no one followed up with Resident 168, but that someone should have. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 PA Code: 201.29(a) Resident rights.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on facility policy review, clinical record review, observation, and interviews with staff and residents, it was determined that the facility failed to protect the resident's right to be free from mental abuse and neglect for two of 34 residents (Residents 21 and 54). Findings include: Review of facility policy, Abuse and Neglect-Clinical Protocol, revised March 2018, revealed, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including the caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of Resident 21's clinical record revealed diagnoses of dementia (a decline in cognitive function that affects daily life) and muscle weakness (when muscles cannot exert the expected amount of force). Observation on July 28, 2025, at 10:09 AM, revealed Employee 1 entering the room of Resident 21, turn off her call bell, and ask what she needed. Resident 21 answered that she needed ice water. Employee 1 replied, I already told you that I'd take care of that, now don't ring your call bell again. Employee 1 then exited the Resident's room. Review of Resident 21's care plan revealed a care plan with a focus area that Resident 21 is at risk for falls, revised on September 28, 2020, and an intervention of keeping the call bell in reach of Resident 21 with a date initiated of April 30, 2020. Review of Resident 54's clinical record revealed diagnoses of anxiety disorder (a condition characterized by excessive fear, worry, and anxiety that interfere with daily life) and difficulty in walking (can stem from various causes, including neurological disorders, musculoskeletal issues, and gait abnormalities). Review of Resident 54's care plan revealed a focus area of, At risk for falls, revised January 9, 2025, with interventions that include, keep call bell in reach, provide assistance to transfer as needed, and reinforce the need to call for assistance, initiated July 31, 2024. Interview with Resident 54 on July 28, 2025, at 12:09 PM, revealed that Employee 1 had told Resident 54 that she cannot use her call bell between 7:00 AM-9:00 AM; 11:00 AM-1:00 PM; and 5:00 PM- 7:00 PM because the staff is serving meals and will not answer call bells. Interview with Director of Nursing on July 31, 2025, at 11:35 AM, revealed that the facility is aware of the alleged abuse by Employee 1 and it should not have occurred. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.18(e)(1) Management.</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were free of unnecessary psychotropic medications for one of five residents reviewed (Resident 4). Findings include: Review of facility policy, titled Psychotropic Medication Use, dated July 2022, with a last review date of June 20, 2025, revealed the following: 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences. 13. Residents receiving psychotropic medications are monitored for adverse consequences. Review of Resident 4's clinical record revealed diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and depression. Review of Resident 4's physician orders revealed an order for buspirone hydrochloride (Buspar- a medication used to treat anxiety) oral tablet 5 MG (milligrams) give one tablet by mouth three times a day for anxiety, dated June 28, 2025. Review of Resident 4's clinical record and Medication Administration Records failed to reveal any side effect monitoring or behavior monitoring of resident identified behaviors with the use of the antianxiety medication buspirone. Review of Resident 4's care plan failed to include that she was receiving an antianxiety medication, any side effect monitoring to be observed for, identification of resident behaviors to monitor for, or any other interventions for the use of the antianxiety medication buspirone. During a staff interview with the Director of Nursing on July 31, 2025, at 11:16 AM, she indicated that she would expect Resident 4 to have been monitored for side effects and behaviors for the use of her antianxiety medication. She further confirmed that Resident 4's care plan should have included her antianxiety medication use as well as side effect and behavior monitoring. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record reviews and resident and staff interviews, it was determined that the facility failed to ensure that resident assessments accurately reflected the resident's status for three of 34 residents reviewed (Residents 3, 4, and 171). Findings include: Review of Resident 3's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting the right side and hypertension (high blood pressure). Review of Resident 3's Medicare 5 Day MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of July 3, 2025, revealed in Section GG. Functional Abilities at Question GG0115. Functional Limitation in Range of Motion that she was coded as having no impairment in her upper extremities. During a staff interview with the Director of Nursing (DON) on July 31, 2025, at 12:27 PM, she confirmed that Resident 3's MDS was coded inaccurately and that she would MDS assessments to be coded accurately. Review of Resident 4's clinical record revealed that diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, opioid dependence and a healing left femur (large bone located in the thigh) fracture. Review of Resident 4's admission Medicare 5 Day MDS with the assessment reference date of June 11, 2025, revealed in Section J. Health Conditions subsection J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment that she was coded as having two or more falls with no injury. Review of Resident 4's clinical record revealed that she had experienced two falls on June 8, 2025, and had sustained a skin tear as a result of one fall. Review of Resident 4's admission Medicare 5 Day MDS with the assessment reference date of June 11, 2025, revealed in Section N. Medications subsection N0450. Antipsychotic Medication Review that she was coded as having gradual dose reduction of her antipsychotic medication on June 6, 2025. Review of Resident 4's clinical record failed to reveal any documentation that a dose reduction of her ordered antipsychotic medication was completed. Review of Resident 4's Significant Change MDS with the assessment reference date of July 3, 2025, revealed in Section J. Health Conditions subsection J1700. Fall History on Admission/Entry or Reentry that she was not coded as having had a fall with a fracture within the last 6 months prior to admission/entry or reentry. Review of Resident 4's clinical record revealed that she experienced a fall on June 26, 2025, at the facility and was identified as having a left femur fracture. Review of Resident 4's Significant Change MDS with the assessment reference date of July 3, 2025, revealed in Section N. Medications subsection N0450. Antipsychotic Medication Review that she was not coded as having physician documentation that a gradual dose reduction of her ordered antipsychotic was clinically contraindicated. Review of Resident 4's clinical record revealed a psychiatric consult note dated June 20, 2025, which indicated that a gradual dosage reduction was clinically contraindicated as it could lead to escalation of her symptoms. During a staff interview with the DON on July 31, 2025, at 11:16 AM, she confirmed that Resident 4's MDS assessments were coded inaccurately and that she would MDS assessments to be coded accurately. Review of Resident 171's clinical record revealed diagnoses that included type 2 diabetes mellitus (body doesn't produce enough insulin or use insulin properly) and cerebral palsy (movement disorder caused by damage to or disruptions in brain development). Review of Resident 171's clinical record revealed she was indicated as receiving tube feedings. An interview with Resident 171 on July 28, 2025, at 11:24 AM, revealed she had never received tube feedings. Review of Resident 171's current and discontinued physician orders failed to reveal orders for tube feedings. Review of Resident 171's quarterly MDS with the assessment reference date of May 16, 2025, revealed Resident 171 was coded as receiving feeding tube while a resident. During an interview with the DON on July 30, 2025, at 1:10 PM, it was revealed that Resident 171's MDS assessment was incorrect. The DON stated it was the facility's expectation that MDS assessments be coded correctly. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Review of Resident 79's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included muscle weakness, need for assistance with personal care, and legal blindness. Observations of Resident 79 on July 28, 2025, at 12:05 PM; and on July 30, 2025, at 12:15 PM, revealed the presence of a large amount of black and gray facial hair on her upper lip and chin. Review of Resident 79's care plan revealed a focus for ADL (Activities of Daily Living - washing face, brushing teeth, personal hygiene) deficit related to weakness dated July 15, 2025, with interventions that included, but were not limited to, assist with daily hygiene, grooming, dressing, oral care and eating as needed dated July 15, 2025, and shower/bath on Wednesday and Friday evening shift, dated July 14, 2025. Observation of Resident 79 on July 31, 2025, at 9:45 AM, continued to reveal the presence of a large amount of black and gray facial hair on her upper lip and chin. Immediate interview with Resident 79 revealed that she had not been offered to be shaved since residing at the facility. She further indicated that she would need help and would like to be shaved. Review of Resident 79's bath/shower task documentation revealed that she received a shower on July 16, 2025; a bed bath on July 18 and 23, 2025; was documented as non-applicable on July 25, 2025; and was documented as refused on July 30, 2025. During a staff interview with the Director of Nursing (DON) on July 31, 2025, at 11:45 AM, Resident 79's observations and interview findings were shared. During a follow-up staff interview with the DON on July 31, 2025, at 12:37 PM, she indicated that Resident 79 had been shaved and confirmed that staff should have offered to shave Resident 79's upper lip and chin on her bath/shower day. Review of Resident 149's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included type 1 diabetes mellitus (condition where pancreas makes very little or no insulin, which leads to high blood sugar levels) and radiculopathy, lumbar region (condition where a nerve root in the lower back is compressed or irritated, leading to pain, numbness, tingling, or muscle weakness that radiates down the leg). Review of Resident 149's care plan included a focus area for activities of daily living (ADLs). The care plan revealed the Resident had a self-care deficit for all ADLs that includes grooming his toenails. Review of Resident 149's annual Minimum Data Set (MDS- periodic assessment of resident needs), dated June 12, 2025, revealed that Resident 149 BIMs (brief interview of mental status) score was 15, indicating cognitive function is intact. During an interview with Resident 149 on July 28, 2025, at 12:10 PM, he stated he hasn't had his toenails trimmed for a long time. The surveyor observed his toenail on the right foot and the great toenail extended approximately an inch from the tip of his toe. The left foot had a sock on, but the Resident said it is just as long, pointing the tip of his toe and touching the end of the nail. Resident 149 added that the podiatrist (foot doctor) was in facility to trim roommate's toenails, and he asked the podiatrist if it was his turn, and the podiatrist responded, not today. Resident 149 was unable to provide the date that their roommate had podiatry care. Review of Resident 149's podiatry services since admission to the facility revealed he consented for podiatry services on May 25, 2022. On June 10, 2022, podiatry services provided the initial visit, documenting the reason was for diabetes mellitus foot care. Podiatry notes stated that all toenails were 2-3 millimeters thick, yellow in color, and crumbly. Podiatrist documented the Resident to receive follow-up care in 2-3 months. Resident 149 received podiatry care on September 8, 2022, November 10, 2022, and was scheduled to be seen on March 23, 2023, but Resident 149 was sick on March 23, 2023, and the appointment had to be cancelled. Based on clinical record review and interview with the Resident he has not received any podiatry services since November 10, 2022. On July 28, 2025, the DON was questioned about scheduled podiatry services for Resident 149 and the surveyor described Resident 149's nails. The DON also observed Resident 149's toenails. On July 29, 2025, at approximately 9:30 AM the DON provided a form titled Ancillary Services that stated, podiatry visits to the facility are</p>		

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NAME OF PROVIDER OR SUPPLIER  Laurel Lakes Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  201 Franklin Farm Lane Chambersburg, PA 17201	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement resident-directed care and treatment consistent with the resident's physician orders and plan of care for one of 34 residents reviewed (Resident 25). Findings include: Review of Resident 25's clinical record revealed she was readmitted to the facility from the hospital on April 21, 2025, with diagnoses that included elevation of levels of liver transaminase (indication of liver stress or injury) and need for assistance with personal care. Review of Resident 25's physician orders revealed an order for Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth at bedtime for hyperlipidemia please stop taking when your liver enzymes are close to normal, with a start date of April 21, 2025. Further review of Resident 25's physician orders failed to reveal any active orders for laboratory work. Review of Resident 25's hospital discharge summary documentation signed on April 21, 2025, revealed She was advised at discharge to stop taking her statin therapy until liver function is rechecked in a few weeks. She was discharged to rehab in a safe and stable condition. Further review of Resident 25's hospital discharge summary documentation signed on April 21, 2025, revealed Change how you take these medications: atorvastatin 10 mg tablet, take 1 tablet (10 mg total) by mouth nightly, please stop taking until your liver numbers are close to normal. What changed: additional instructions. The document was check marked alongside that order, indicating that it had been put into the system as it read. Review of Resident 25's physician notes revealed a physician note dated April 22, 2025, that read, in part, For Transaminitis-the statin was placed on hold. CT scans and abdominal ultrasounds did not provide any causes for this. The liver enzymes were improving after the statin was held. Continue to hold the statin, recheck the liver enzymes in a few weeks with recommendations to restart atorvastatin 10 mg when the labs are normal. Review of Resident 25's physician notes revealed a physician note with an effective date of July 24, 2025, that read, in part, For Hyperlipidemia continue to hold Atorvastatin until labs are checked in a few weeks. Review of Resident 25's 2025 April, May, June, and July MAR (Medication Administration Record- documentation for medication/treatment administered or monitored), revealed Resident 25 received the Atorvastatin medication on all days of those months from April 21, 2025, through July 29, 2025. During an interview with the Director of Nursing (DON) on July 30, 2025, at 1:13 PM, the surveyor questioned the order for the atorvastatin being inconsistent with the physician notes and why the liver enzyme laboratory work was never ordered. Interview with the DON on July 31, 2025, at 12:38 PM, revealed she would expect that the medication would have been held, and labs would have been obtained per the physician notes and plan of care. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of two residents reviewed for range of motion (Resident 46). Findings include: Review of facility policy, titled Restorative Nursing Services, with a last revision date of July 2017, and a last review date of June 20, 2025, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Review of Resident 46's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included muscle weakness, chronic obstructive pulmonary disorder (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations), and chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats). During an interview with Resident 46 on July 29, 2025, at 11:18 AM, she indicated that she does not feel she is getting enough therapy to prepare her for her return home. Review of Resident 46's Physical Therapy Discharge summary dated [DATE], indicated in section titled RNP [Restorative Nursing Program] to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNP's has been completed with the IDT: bed mobility and ROM [range of motion] (Active). Review of Resident 46's care plan revealed a care plan focus for Restorative Nursing: Active Range of Motion with an intervention of Active ROM to upper/lower extremities per resident tolerance with morning and bedtime care, with an initiated date of July 20, 2025. Further review of Resident 46's care plan failed to reveal a RNP for bed mobility. Review of Resident 46's task documentation for her ROM RNP revealed that the program was not initiated until July 20, 2025, and was documented as Not Applicable on July 21, 2025, day shift and on July 22, 23, and 24, 2025, for both day and evening shifts. During a staff interview with the Director of Nursing on July 31, 2025, at 11:20 AM, she indicated that she would have expected both of Resident 46's Restorative Nursing Programs to have been initiated when she was discharged from therapy on June 27, 2025, and that she would expect staff to provide and document a resident's RNP's accordingly. She further confirmed that Not Applicable was not an appropriate documentation response to utilize. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on review of facility policy, clinical record reviews, and staff interview, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice for two of two residents reviewed for dialysis (Residents 16 and 46). Findings include: Review of facility policy, titled Hemodialysis Catheters - Access and Care of, last reviewed June 20, 2025, read, in part, The nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (intervention if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis being given. 5. Observations post-dialysis. Review of Resident 16's clinical record revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to). Review of Resident 16's physician orders revealed an order to check dialysis access site dressing every shift, reinforce as needed, and notify the physician as needed. Further review of Resident 16's clinical record failed to reveal evidence that Resident 16's dialysis access site dressing checks were being completed as ordered. During an interview with the Director of Nursing (DON) on July 31, 2025 at 11:15 AM, it was revealed that a transcription error had occurred and the physician's order did not populate on Resident 16's medication or treatment administration record. The facility could not provide documentation that Resident 16's dialysis access site dressing checks were being completed. The DON stated it was the expectation of the facility that physician orders be transcribed correctly and dialysis access site dressing checks to be completed as ordered and documented. Review of Resident 46's clinical record revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to). Review of Resident 46's physician orders revealed an order to check dialysis access site dressing every shift, reinforce as needed, and notify the physician as needed. Further review of Resident 46's clinical record failed to reveal evidence that Resident 16's dialysis access site dressing checks were being completed as ordered. During an interview with the DON on July 31, 2025 at 11:20 AM, it was revealed that a transcription error had occurred and the physician's order did not populate on Resident 46's medication or treatment administration record. The facility could not provide documentation that Resident 46's dialysis access site dressing checks were being completed. The DON stated it was the expectation of the facility that physician orders be transcribed correctly and dialysis access site dressing checks to be completed as ordered and documented. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, medication information review, and staff interview, it was determined that the facility failed to ensure that was free from unnecessary medications for one of five residents reviewed for unnecessary medications (Resident 4). Findings include: Review of diclofenac dosage guidelines in the Physician's Desk Reference (a comprehensive resource for drug information, providing healthcare professionals with trusted prescribing information and patient adherence resources) revealed the following: Diclofenac gel is only indicated for the relief of the pain of osteoarthritis of joints amenable to topical treatment such as the knees and hands. The gel was not evaluated for use on joints of the spine, hip, or shoulder with dosage guidelines of 4 g (4.5 inches) topically per knee, ankle, or foot joint 4 times daily (Max: 16 g/day per lower extremity joint) and/or 2 g (2.25 inches) topically per elbow, wrist, or hand joint 4 times daily (Max: 8 g/day per upper extremity joint). Do not exceed a total dose of 32 g/day over all affected joints. Do not use on more than 2 body areas at the same time. Review of Resident 4's clinical record revealed that diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, opioid dependence and a healing left femur (large bone located in the thigh) fracture. Review of Resident 4's clinical record revealed that she was initially admitted to the facility on [DATE], with an order for diclofenac sodium external gel 1 % apply to painful joints topically four times a day for pain. Review of Resident 4's pharmacist's admission medication regimen review dated June 9, 2025, revealed that Resident 4 had an incomplete order for the diclofenac ointment and to update the order with location of body and stop date or date for reevaluation. The review failed to identify that the diclofenac ointment did not have a specified dose to apply indicated in the order. Review of Resident 4's clinical record revealed that she was transferred and admitted to the hospital on [DATE], and was readmitted to the facility on [DATE]. Review of Resident 4's current physician orders revealed an order for diclofenac sodium external gel 1 % apply to back, hands, knees, legs topically four times a day for pain, dated June 28, 2025. Review of Resident 4's pharmacist's admission medication regimen review dated June 30, 2025, failed to identify that the diclofenac ointment did not have a specified dose to apply indicated in the order and failed to identify that applying the ointment to the back and legs may not be appropriate. Review of Resident 4's Medication Administration Records for June 2025 and July 2025 revealed that she had received the diclofenac 127 times between June 28, 2025, and July 30, 2025. During a staff interview with the Director of Nursing on July 31, 2025, at 11:16 AM, she confirmed that she would have expected the pharmacist's medication regimen review on June 9 and 30, 2025, to have identified that Resident 4's diclofenac order did not have a specified dose for nursing staff to apply. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of select facility grievances, review of the menu, completion of one meal test tray, and resident and staff interviews, it was determined that the facility failed to provide foods that are palatable and at an appetizing temperatures at one of one meal observed. Findings include: Review of facility grievance filed on January 9, 2025, read, in part, cold food. Review of facility grievance filed on January 24, 2025, read, in part, food is cold. Review of facility grievance filed on July 1, 2025, read, in part, food is served cold all the time. Review of facility grievance filed on July 4, 2025, read, in part, after waiting 20 minutes, lunch was served and the cheeseburger was cold. Interview with Resident 25 on July 28, 2025, at 11:43 AM, she revealed the temperature of the food is poor when it is served. Interview with Resident 124 on July 28, 2025, at 11:50 AM, she revealed the food is always cold. During a group interview on July 29, 2025, at 11:05 AM, Resident 60 stated that food is always cold by the time it is served at the end of her hallway. Resident 168 revealed she filed a recent grievance regarding a cold meal that she received. Resident 104 stated that food service is lousy. Review of facility menu on July 31, 2025, revealed the lunch menu consisted of Homestyle Meatloaf, Au Gratin Potato, Broccoli, and Chilled Fruit Cup. A test tray was completed on July 31, 2025, at 11:38 PM, with Employee 3 (Certified Dietary Manager) the meal tray included Ham loaf, Au Gratin Potato, Broccoli, and Chilled Fruit Cup. The test tray was placed on a meal cart and delivered to B-Wing Hall with other trays being delivered at that time, 14 minutes had elapsed between with the test tray was prepared from the service line and presented for evaluation. Interview with Employee 3 on July 31, 2025, at 11:38 AM, revealed hot food temperatures should be 135 degrees Fahrenheit or above at the point of service. Employee 3 took temperatures of the food items at the time the test tray was served for evaluation. At that time, the ham loaf had a recorded highest temperature of 123 degrees, the broccoli had a recorded highest temperature of 121 degrees and the fruit cup had a recorded lowest temperature of 66 degrees; the ham loaf, broccoli, and fruit cup were not at appetizing temperatures when taste tested. The surveyor discussed the results of the test tray with Employee 3. During an interview with Employee 3 on July 31, 2025, at 11:43 AM, he revealed the fruit cups should have been kept on ice or under refrigeration up until the point of service, rather than on a sheet pan on top of the meal carts. During an interview with the Director of Nursing on July 31, 2025, at 12:37 PM, the surveyor revealed the concern with food palatability and the test tray results, she revealed her expectation that food should be served at palatable and appetizing temperatures. 28 Pa. Code 201.14. Responsibility of licensee</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on observation, review of select facility documentation, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents received food that accommodated their preferences for two of two residents reviewed for meal accuracy (Residents 102 and 104). Findings include: During an interview with Resident 104 on July 29, 2025, at 11:05 AM, he revealed that he frequently does not receive the meal he has selected. Review of the lunch menu for July 29, 2025, revealed the main entree was honey dijon chicken, and the alternate entree was a salmon patty. Observation of Resident 102 on July 29, 2025, at 12:10 PM, revealed he was eating his lunch in his room, and he was scraping the sauce off of his chicken. During an immediate interview with Resident 102, he revealed that he did not receive what he had requested for lunch, and that he did not like what he was served. At the time of the observation, Resident 146, Resident 102's roommate, stated that he had put a timely request in the book for himself and Resident 102 to receive the alternate entree choice for the day, a salmon patty. Resident 146 confirmed that he had received the salmon patty, and stated he was not sure why Resident 102 had not. Review of Resident 102's meal ticket did not reveal any information regarding the entree he was to be served. During an interview with Employee 2 (Dietary Aide) who was present at the nursing desk immediately following the observation, she revealed that if residents would like an alternate meal, they put their name on a meal change request log which resides at the nursing desk. Then their alternate meal choice would be written on their meal ticket so it can be plated correctly. Employee 2 provided the meal change request log for July 29, 2025. Review of the log revealed that Resident 102 and Resident 146's names were on the log, and the entree they wanted for lunch was a salmon patty. During an immediate interview with Employee 2, she revealed that she thought Resident 102's name said Resident 104's name. She confirmed that she had not given Resident 102 a salmon patty but had instead given it to Resident 104. Employee 2 stated that she would go to the kitchen to see if she could obtain a salmon patty for Resident 102. During an interview with Resident 104 on July 29, 2025, at approximately 12:15 PM, he confirmed that he had not made a request for an alternate entree for lunch on that date, but that he had received the alternate entree, a salmon patty. Email correspondence received from the Director of Nursing on July 31, 2025, 10:39 AM, revealed the expectation that residents should receive the correct food per their preference. 28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, review of facility temperature logs, and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Observation of the dish machine in the main kitchen on July 28, 2025, at 1:22 PM, revealed kitchen staff were washing dishes from lunch, and the wash temperature of the dish machine read 138 degrees Fahrenheit (F). During an interview with Employee 3 (Certified Dietary Manager) on July 28, 2025, at 1:23 PM, he revealed the dish machine should be running at a minimum wash temperature of 150 degrees F. The surveyor questioned if he could link a sanitizing solution to the machine for safe use at a lower temperature and if he could have maintenance staff service the machine. Employee 3 revealed he could link the sanitizer to the machine as well as contact maintenance staff. Observation of the dish machine in the main kitchen on July 29, 2025, at 1:21 PM, revealed kitchen staff were washing dishes from lunch, and the wash temperature of the dish machine read 136 degrees F. Interview with Employee 3 on July 29, 2025, at 1:22 PM, revealed he had maintenance staff service the machine that morning and it had been running between 155-160 degrees F during breakfast. He further revealed he did not link the sanitizing solution to the machine. Observation of the dish machine in the main kitchen on July 30, 2025, at 1:11 PM, revealed kitchen staff were washing dishes from lunch, and the wash temperature of the dish machine read 140 degrees F. Review of the December 2024 dish machine temperature log revealed rinse temperatures were recorded below the minimum safe temperature on all days and at all meals during that month, and no corrective action was noted. During an interview with the Director of Nursing on July 31, 2025, at 12:37 PM, she revealed her expectation that kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 211.6(f) Dietary services</p>		