

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395647	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Gettysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 1075 Old Harrisburg Road Gettysburg, PA 17325	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>40010</p> <p>Based on policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for three of sixteen residents reviewed (residents 17, 19, and 29).</p> <p>Findings include:</p> <p>Review of facility policy titled, Comprehensive Care Planning Standard, last revised November 15, 2017, revealed, in part, The care plan framework will include the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Care plans are evaluated and revised as the resident's status changes and with any goals or treatment refusals.</p> <p>Review of Resident 17's clinical record revealed diagnoses of muscle weakness (weakness of muscle movements) and fracture of the left humerus (bone in the part of the arm closest to the body).</p> <p>Observation on Resident 17 on April 29, 2024, at 12:24 PM, revealed Resident 17 sitting in a wheelchair with no brace on her left arm. When questioned about the brace that was sitting on a chair behind where the resident was sitting, Resident 17 replied that she only wears the brace at nighttime. Resident 17 was also using supplemental oxygen at this time.</p> <p>Review of Resident 17's care plan, on April 29, 2024, revealed an active care plan for, Activities of daily living function impaired due to left humeral fracture. This care plan had an intervention of hinged elbow brace to be work at all times, with a date initiated of February 16, 2024. Further review of Resident 17's care plan failed to reveal anything regarding Resident 17's supplemental oxygen use.</p> <p>Review of Resident 17's physician orders on April 29, 2024, revealed a current physician's orders for supplemental oxygen at 2 liters per minute to start on March 24, 2024, and an order for Resident 17 to wear her hinged elbow brace at hours of sleep only starting on March 30, 2024.</p> <p>Interview with the Director of Nursing (DON) on May 2, 2024, at 10:12 AM revealed that Resident 17's care plan should have been updated to include her use of supplemental oxygen and should have been updated when the physicians order for her hinged elbow brace changed to only be worn at hours of sleep.</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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 19's clinical record revealed diagnoses that included: muscle weakness, peripheral vascular disease (disease or disorder of the circulatory system outside of the brain and heart), and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Observation of Resident 19 in her room on April 29, 2024, at 10:13 AM, revealed she had a soft boot on her left foot, her other foot was covered by a blanket.</p> <p>Review of Resident 19's care plan on April 29, 2024, at 12:45 PM, failed to reveal and notation of heel boots or heel protective devices.</p> <p>During an interview with the DON on May 1, 2024, at 9:59 AM, she revealed Resident 19 wears heel protector boots to prevent skin breakdown (development of wounds).</p> <p>Review of Resident 19's care plan on May 1, 2024, at 2:05 PM, revealed a focus area: Potential for skin breakdown due to fragile skin, incontinence (the loss of bladder control), limited ability to move by myself, poor nutrition initiated on April 12, 2024, with an intervention for Apply heel protectors as needed for skin protection, initiated April 30, 2024.</p> <p>Interview with the DON on May 2, 2024, at 10:04 AM, revealed she would expect the heel protectors to be on Resident 17's care plan prior to April 30, 2024.</p> <p>Review of Resident 29's clinical record on April 30, 2024 at approximately 2:00 PM, revealed diagnoses that included cerebral infarction (damage to tissues in the brain due to loss of oxygen to the area) and muscle weakness (lack of strength).</p> <p>Review of Resident 29's physician orders revealed an order written on January 12, 2024 to apply left resting hand splint upon rising in the morning and remove at bedtime.</p> <p>Review of Resident 29's comprehensive care plan failed to reveal a focus area or intervention for the use of a left-hand splint.</p> <p>During an interview on May 1, 2024 at 1:15 PM, with the Nursing Home Executive Director and Director of Nursing (DON) the surveyor requested additional information regarding Resident 29's care plan not including the left hand splint.</p> <p>During a follow up interview on May 2, 2024 at 10:12 AM with the Nursing Home Executive Director and DON, the DON stated the Resident 29's care plan had been revised to include use of the left-hand splint. The DON also stated it was the facility's expectation that the care plan would have been updated timely.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>48484</p> <p>Based on policy review, observation, record review, and staff interviews, it was determined the facility failed to provide appropriate care and services for residents receiving a tube feeding for one of 16 residents reviewed (Resident 19).</p> <p>Findings include:</p> <p>Review of facility policy, titled Tube Feeding Standard, last revised April 1, 2016, revealed, in part, Feeding solution is hung per manufacturer recommendations. All bags and tubing are replaced daily. Irrigation syringes are labeled with resident name, date, and are changed daily on 11-7 shift.</p> <p>Review of Resident 19's clinical record revealed diagnoses that included: surgical aftercare following surgery on the digestive system, dysphagia (difficulty swallowing), and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of Resident 19's physician orders revealed an order for Enteral Feed every night shift, Change Enteral Feeding set, container bag, tubing, with a start date of April 13, 2024.</p> <p>Observation in Resident 19's room on April 30, 2024, at 12:02 PM, revealed Resident 19's enteral feed tubing and the hanging bag of water for flushing were dated April 29, 2024, at 2:50 AM.</p> <p>During an interview with the Director of Nursing (DON) on April 30, 2024, at 1:12 PM, the surveyor revealed the observation of the tubing and water bag not dated as changed on the prior night shift.</p> <p>During a follow-up interview with the DON on May 1, 2024, at 9:57 AM, she revealed the tubing was not changed on night shift on April 30, 2024, and she would expect tubing and hanging bags to be changed per physician order and facility policy.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the physician reviewed and responded to pharmacy review recommendations for one of five residents reviewed for unnecessary medications (Resident 24).</p> <p>Findings include:</p> <p>Review of facility policy titled Drug Regimen Review last revised February 2023, read, in part A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, physicians and the care planning team. This should be: Documentation of the date each medication regimen review is completed on the appropriate form and notation of the finding in the medical record or other designated site.</p> <p>Review of Resident 24's clinical record revealed diagnoses that included: Myasthenia gravis (a neuromuscular disorder that leads to weakness of skeletal muscles), anxiety disorder (a persistent feeling of worry, nervousness, or unease), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things).</p> <p>Review of Resident 24's clinical record on April 30, 2024, at 9:30 AM, failed to reveal a medication regimen review completed by a licensed pharmacist in the month of November 2023.</p> <p>Email correspondence with the Director of Nursing (DON) on May 1, 2023, at 9:40 AM, revealed I cannot locate the pharmacy recommendation for November 2023 for [Resident 24].</p> <p>During a follow up interview with the DON on May 1, 2023, at 1:45 PM, she confirmed she was unable to locate Resident 24's pharmacy recommendation from November 2023, and she would expect pharmacy recommendations to be available and reviewed by the physician.</p> <p>28 Pa. Code 211.9(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		