STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395647	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spiritrust Lutheran the Village at Gettysburg	1075 Old Harrisburg Road Gettysburg, PA 17325

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the resident right to formulate an advanced directive for one of 12 residents reviewed (Resident 39).Findings include: Review of facility policy, titled Advance Care Planning Standard last reviewed [DATE], read, in part, Purpose: To assist each resident to exercise his/her right to make knowledgeable choices about care and treatment or to decline treatment. Incorporate the residents' choices into the medical record and orders related to treatment, care and services. Review of Resident 39's clinical record revealed diagnoses that included presence of right artificial knee joint, encounter for orthopedic aftercare, and muscle weakness. Review of Resident 39's clinical record failed to reveal a physician order or a care plan for her code status (a medical designation that indicates what life saving treatments a patient would or would not want if their heart or breathing stops). Review of Resident 39's hard paper medical chart on [DATE], at 12:56 PM, failed to reveal a POLST form (Physician Orders for Life Sustaining Treatment- a medical order that allows seriously ill or frail individuals to specify the types of medical treatment they want during emergencies). During an interview with Employee 3 (Registered Nurse) on [DATE], at 12:58 PM, the surveyor asked if Employee 3 could find Resident 39's code status in her electronic or paper medical record. Employee 3 stated it is usually in the physicians orders and under additional instructions in the electronic chart, and she was unsure of why she didn't have a POLST in her paper chart for reference. Employee 3 couldn't find it after one minute and stated she would not wait any longer to search at that point, and if Resident 39 started to code (a life threatening medical emergency requiring immediate resuscitation efforts), she would treat her as a full code and start performing CPR (Cardiopulmonary Resuscitation, an emergency procedure used to maintain blood flow and oxygen to vital organs when the heart stops beating). During an interview with Employee 8 (Licensed Practical Nurse) on [DATE], at 1:03 PM, she revealed if she could not find a resident's code status in their electronic or paper medical record, she would start CPR and treat them as a full code. During an interview with Resident 39 on [DATE], at 1:06 PM, she revealed Employee 9 went over advance directive information with her when she was admitted to the facility, and that her wishes are for DNR (Do Not Resuscitate- a medical order indicating that a person does not want CPR or other life-saving measures if their heart or breathing stops). Review of Resident 39's clinical record revealed a note written by Employee 9 (Social Worker) on [DATE], that stated POLST form reviewed, continues to decline to complete POLST but does request DNR code status. Interview with the Director of Nursing on [DATE], at 11:11 AM, she revealed Resident 39's DNR code status order was missed from the batch physician orders and failed to be transcribed to the electronic chart orders. She stated that she would expect the order would have been put in electronically to be easily found by nursing staff in the event of a life threatening emergency. 28 Pa. Code 201.29 (a) Resident Rights28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services28 Pa. Code 211.5 (f)(i) Medical Records

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on facility policy review, observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that services provided meet professional standards of practice for one of 12 residents reviewed (Resident 39). Findings include: Review of facility policy, titled Medication Administration last reviewed March 23, 2026, read, in part, Purpose: Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. All medications are to be given in accordance with the 5 rights of medication administration: Right Time- Medications are administered within the time frame specified by the physician order. Review of Resident 39's clinical record revealed diagnoses that included presence of right artificial knee joint and muscle weakness. Review of Resident 39's physician orders revealed an order for Ampicillin Sodium Intravenous (IV) Solution Reconstituted 2 gram, use 2000 milligram intravenously every 6 hours for cellulitis (infection), with a start date of April 15, 2026. Review of Resident 39's MAR (Medication Administration Record - record of medications and treatments administered) revealed she is to get the Ampicillin IV medication at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM, daily. Review of Resident 39's care plan revealed a care plan focus area, I am at risk of complications as I have IV therapy for infection, with an intervention for IV therapy as ordered, initiated on April 14, 2026. Observation and resident interview in Resident 39's room on April 28, 2026, at 12:28 PM, revealed she had not yet received her IV medication to be administered at 12:00 PM and she was not sure why. Additional surveyor observation on April 28, 2026, at 1:13 PM, revealed the IV antibiotic had yet to be administered for the noon dose. During an interview with the Director of Nursing (DON) on April 29, 2026, at 1:45 PM, the surveyor revealed the concern with the late IV administration on April 28, 2026. Review of Resident 39's clinical record revealed a nursing progress note from April 29, 2026, at 2:58 PM, that read, IV Ampicillin due 1200 on 4/28/26 given pass admin time and marked late on MAR. Med given at 1320 and marked on MAR at 1350. No signs or symptoms of infection noted. Incision to right knee well approximated, no drainage or redness noted. [Physician] aware with no new orders. Husband and resident both aware and voice no concerns over time that dose was given. Review of Resident 39's April MAR report revealed Resident 39's ampicillin dose was marked as given late on two other occasions. For the 12:00 AM dose on April 27, 2026, it was noted to be documented as administered at 2:20 AM; for the 12:00 AM dose on April 30, 2026, it was noted to be documented as administered at 1:56 AM. Interview with the DON on April 30, 3036, at 12:31 PM, revealed nurses can start the administration of a medication but get tasked with other priorities such as ADL care/toileting for the resident or an emergent situation that would require attention, and sign as completed at a later time. If those situations occur, a progress note should be put into the record as to why the medication was administered late or signed late but given on time. She further revealed her expectation that medications are administered timely and as ordered. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, facility policy review, and clinical record review, it was determined that the facility failed to ensure that a resident receiving wound care was consistent with infection control standards of practice when placing medication in the base of a wound for one of 12 residents reviewed (Resident 7).Findings include: Review of the facility policy, titled Dressing Change, Clean last reviewed March 23, 2026, states the following steps:1. Place plastic bag near foot of bed to receive soiled dressing.2. Create clean field with paper towels or towelette drape.3. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound.4. Open dressing pack.5. Put on first pair of disposable gloves.6. Remove soiled dressing and discard it in plastic bag.7. Dispose of gloves in plastic bag.8. Put on second pair of disposable gloves.9. Pour prescribed solution onto gauze to be used for cleaning, if required.10. Cleanse wound with prescribed solution.11. Apply prescribed medication if ordered.12. Apply dressings and secure with tape.13. Remove gloves and discard with all unused supplies in plastic bag. A review of the clinical record for Resident 7 on April 30, 2026, revealed clinical diagnoses that included unstageable sacral pressure ulcer (a wound where the true depth cannot be determined because it is covered by slough) and hospice status (end of life). A review of Resident 7's physician orders dated April 2026, included an order for sacral wound care to be completed daily and as needed if dislodged or soiled. The wound care orders specify to cleanse the area with normal saline solution, pack with calcium alginate silver, and cover with a border foam dressing. Observation of wound care on Resident 7 on April 30, 2026, at 9:45 AM, revealed Employee 6 (Licensed Practical Nurse) using her clean gloved hand to remove a pen marker from under her PPE gown, then lifted the cuff of her scrub jacket to check the time, labeled the border foam dressing, then used the same gloved hand to pick up the calcium alginate silver and place it into the wound bed. During an interview with the Nursing Home Administrator (NHA) on April 30, 2026, at 11:31 AM, the NHA agreed that policy should be followed for dressing changes. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to provide respiratory care and services consistent with professional standards of practice for two of 12 residents reviewed for respiratory care (Resident 5 and 37). Findings include: Review of the facility policies revealed that they did not have a policy that specifically spoke about supplemental oxygen use or use of a nebulizer. Review of Resident 5's clinical record revealed diagnoses that included Asthma (a chronic, non-curable lung disease causing airway inflammation and muscle tightening) and obstructive sleep apnea (serious, common sleep disorder where throat muscles relax excessively, causing repeated airway collapse and breathing pauses [apnea] during sleep). Observation of Resident 5 on April 27, 2026, at 10:56 AM, revealed Resident 5 lying in bed. Resident 5 was wearing a nasal canula (oxygen delivery device) and receiving supplemental oxygen at 3 liters per minute and the oxygen tubing was not dated. Observation of Resident 5 on April 29, 2026, at 11:46 AM, revealed Resident 5 lying in bed. Resident 5 was wearing a nasal canula (oxygen delivery device) and receiving supplemental oxygen at 3 liters per minute and the oxygen tubing was not dated. Review of Resident 5's care plan revealed a care plan of: I have potential complications as I have asthma and restrictive lung disease, and an intervention of: give oxygen therapy as ordered, with a date initiated on June 17, 2016. Review of current physician orders for Resident 5 revealed an order for oxygen via nasal canula at 2-4 liters per minute, starting December 4, 2025. Interview with the Director of Nursing (DON) on April 29, 2026, at 1:15 PM, revealed that Resident 5's oxygen tubing should have been dated when it was applied or changed. Further interview revealed that the facility did not have a policy regarding supplemental oxygen use. Review of Resident 37's clinical record revealed diagnoses that included heart failure (a chronic, progressive condition where the heart cannot pump blood efficiently, leading to fatigue, shortness of breath, and fluid buildup) and muscle weakness (weakness in the muscles not explained by any medical diagnosis). Observation of Resident 37 on April 27, 2026, at 12:56 PM, revealed Resident 37 sitting in her recliner. On the table beside her, her nebulizer mask was sitting out on the table not covered or in a bag. Observation of Resident 37 on April 29, 2026, at 10:46 AM, revealed Resident 37 sitting in her recliner. On the table beside her, her nebulizer mask was sitting out on the table not covered or in a bag. Review of Resident 37's care plan revealed a care plan with the focus area of, I have difficulty breathing due to CHF (congestive heart failure), with a revision date of January 11, 2025. Review of Resident 37's physician orders revealed an order for albuterol sulfate solution given via nebulizer daily at bedtime, with a start date of March 23, 2026. Interview with the DON on April 29, 2026, at 2:15 PM, revealed that she would expect the resident's mask to be cleaned and put away after use. Further interview revealed that the facility did not have a policy regarding nebulizer use. 28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(3) Nursing services28 Pa. Code 211.12(d)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on facility policy review, review of facility menu extension sheets, review of select facility recipe, observations, and staff interviews, it was determined that the facility failed to follow the diet extension sheets to provide a menu to meet the needs and preferences of residents for five of 47 residents reviewed with similar diet needs (Residents 6, 21, 28, 29, and 35).Findings include: Review of facility policy, titled Recipes last reviewed March 23, 2026, read, in part, Recipes will be used in preparation of all menu items. To ensure proper nutritional adequacy, portion control, and cost of the menu item being prepared. Recipes are to be adjusted for facility yield and must be followed exactly. Review of facility policy, titled Production Sheet last reviewed March 23, 2026, read, in part, A production sheet is developed for each meal based on the menu cycle. To ensure that the production team prepares menu items in the correct quantity and adheres to company standards of food quality. There is a production sheet for each meal. Included on this sheet are: All items to be prepared for that meal, their recipe number, and portion size. Quantity to be produced based on resident diet census form for all items listed. Review of facility menu extension sheets revealed the main meal served on Wednesday April 29, 2026, was to consist of two Baked Manicotti with tomato sauce (6 ounces- unit of measure), 4-ounces of Vegetable Blend, a 2-ounce Warm Dinner Roll with Butter, and one slice of Pound Cake with Fruit Topping. Observation during tray line meal service on April 29, 2026, 11:45 AM, revealed Residents 6, 21, 28, 29, and 35 were served only one manicotti. Observation of their meal tray tickets revealed they should have been served two. On April 29, 2026, at 11:56 AM, Employee 2 (Dietary Employee) paused the tray line meal service to make more fish flounder for the alternate menu and asked how the meal service was going. The surveyor revealed the concern with only one manicotti being served instead of two. Employee 2 then stated the manicotti were pretty big so he only gave one as they were at least three ounces. Review of facility recipe for the manicotti on April 29, 2026, at 11:59 AM, revealed one portion size of the manicotti was 6 ounces. During an interview with Employee 1 (Director of Dining Services) on April 29, 2026, at 12:17 PM, revealed he weighed one manicotti from the pan on the steam table and it weighed approximately 5 ounces, but he was in agreement that it was the incorrect portion size. Interview with the Nursing Home Administrator on April 29, 2026, at 12:17 PM, she revealed she would expect recipes to be followed and appropriate portions to be served during meal service. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, product label, policy review, and staff interviews, it was determined that the facility failed to maintain a safe environment that supports infection prevention and control for glucometer cleaning for two of three nursing units reviewed. Findings include: A review of the facility policy, titled Glucometer: Accountability of Medical Equipment Standard, last reviewed March 23, 2026, states, The glucometer shall be cleaned per manufacturer's instructions before use, after use, and when stored. A review of the manufacturer's instructions for cleaning and disinfecting the specific brand of glucometer that the facility used recommends an EPA (Environmental Protection Agency)- registered disinfectant wipe (such as bleach wipes) to clean all external surfaces, including the front, back and sides, ensuring the disinfectant stays wet on the surface for the required contact time, typically about 4 minutes. During an interview with Employee 3 (Licensed Practical Nurse), the Employee was asked to review her process during use of the glucometer on a resident. Employee 3 demonstrated cleaning the glucometer after use with alcohol wipes and placing it on the medication cart to air dry prior to storing it back in the medication cart. The Employee pulled a container of bleach wipes (EPA recommended disinfectant) from the medication cart and stated, I probably should use these, but I'm old school and prefer alcohol wipes. During an interview with Employee 4 (Licensed Practical Nurse), the Employee was asked to review her process during use of the glucometer on a resident. Employee 4 stated the following, After use, I wipe the glucometer down with alcohol wipes, and lay it down to air dry, then store it in the medication cart. During an interview with the Nursing Home Administrator (NHA) on April 30, 2026, at 11:30 AM, the NHA was asked if she expected staff to disinfect the glucometer per manufacturer's recommendations. The NHA replied, I expect staff to follow the policy. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services