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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/20/2025 |
| NAME OF PROVIDER OR SUPPLIER Gettysburg Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 867 York 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| F 0600 Level of Harm - Actual harm Residents Affected - Few | <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, facility documentation review, and staff interview, it was determined the facility failed to ensure each resident is free from neglect, which resulted in actual harm as evidenced by displaced hardware securing a fracture for one of three residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>Review of facility policy, titled OPS 300 Abuse Prohibition with a last revision date of October 24, 2022, revealed Neglect is defined as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of Resident 3's clinical record revealed diagnoses that included chronic kidney disease (longstanding disease of the kidneys leading to renal failure), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart), and history of falling.</p> <p>Review of Resident 3's care plan revealed an intervention for provide resident/patient with extensive assist of 2 for bed mobility, dated March 12, 2024.</p> <p>Review of Resident 3's clinical record progress notes revealed a note dated March 15, 2025, at 7:46 AM, that indicated around 5:40 AM the Resident was noted to be on the floor, was complaining of left knee pain, right hip pain, and worsening left arm pain. The Resident rated all her pain 10/10, unable to move lower extremities and left arm, and the left knee warm to touch. The note indicated that Resident 3's provider was made aware and orders were given for x-rays of both hips, pelvis, both knees, and left forearm; as well as orders for an additional pain medication and to hold their anticoagulant (blood thinning) medication for two days.</p> <p>The note further indicated that Employee 4 (agency nurse aide) said, she was trying to change resident when she rolled out the opposite side of bed and landed with her feet touching the ground first.</p> <p>Further review of Resident 3's progress notes revealed a note dated March 15, 2025, at 12:04 PM, that indicated that the x-ray revealed an appliance in Resident 3's left arm with an abnormality noted. The note further indicated that Resident 3's provider was made aware and an order was given to transport Resident 3 to the hospital.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident 3's x-ray report dated March 15, 2025, revealed that there was a sideplate and screws bridging a distal humerus fracture. A screw in the sideplate is broken and the distal portion of the sideplate is no longer attached to the humerus.</p> <p>Review of facility provided investigation witness statement from Employee 4 dated March 15, 2025, revealed that Employee 4 was providing care, and she had Resident 3 on her side but she rolled off I grabbed her, but she still fell.</p> <p>Review of the facility reported incident, revealed that the facility suspended Employee 4 immediately at time of Resident 3's fall. The report also confirmed that Employee 4 neglected to follow Resident 3's care plan by failing to provide extensive assist of 2 people for bed mobility and failed to properly turn and reposition Resident 3 toward them while providing care, which resulted in Resident 3 falling out of bed and experiencing actual harm as evidenced by displaced hardware securing a fracture requiring a transfer to the hospital for treatment. The facility terminated the contract for Employee 4.</p> <p>Review of facility provided training information revealed that in December 2024, the facility completed education with nursing staff on resident safety during turning and repositioning, and objectives included ability to quickly identify potential safety issues prior to turning resident; how to safely turn and reposition a resident; and identify ways to prevent injury during turning and repositioning. Employee 4 had signed the Employee Training Sign-In Sheet as an attendee.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and Employee 1 on March 20, 2025, at 10:51 AM, the NHA confirmed that she would expect staff to follow a resident's care plan.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1)(e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on facility policy review, clinical record reviews, facility incident report review, hospital records review, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 16 residents reviewed (Residents 1 and 5).</p> <p>Findings include:</p> <p>Review of facility policy, titled NSG115 Physician/ Advanced Practice Provider (APP) Notification, with a last revision date of December 16, 2024, revealed, in part, Upon identification of a patient who has a change in condition, abnormal laboratory values, or diagnostic tests, a licensed nurse will: perform appropriate clinical observations, collect pertinent patient information, and report to physician/Advanced Practice Provider (APP); complete the eInteract Change in Condition UDA and determine if the change in condition requires immediate or non-immediate notification, and notify physician/APP as applicable.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included hypertension (high blood pressure), bradycardia (heart rate lower than 60 beats per minute), and chronic pain syndrome.</p> <p>Review of Resident 1's progress notes revealed a note written by Employee 8 (Registered Nurse [RN]) dated March 1, 2025, at 3:49 PM, that indicated Resident 1's family was at the bedside requesting that Resident 1 be transferred to the hospital right away because of confusion, low blood pressure, and unrelieved pain.</p> <p>Review of Resident 1's Medication Administration Record revealed that she received oxycodone on March 1, 2025, at 1:41 PM, for a pain level of 10; and received Tylenol at 2:30 PM for continued pain level of 8.</p> <p>Review of Resident 1's vital signs documentation for March 1, 2025, at 3:25 PM, revealed a temperature of 96.7 degrees Fahrenheit (normal 98.6 degrees Fahrenheit), a pulse rate of 76 (normal 60-100), a respiratory rate of 22 per minute (normal 16-20 per minute), a blood pressure of 77/50 (normal 120/80), and an oxygen saturation of 93% on room air (normal 95-100%).</p> <p>Review of Resident 1's clinical record progress notes revealed a note written by Employee 6 (RN), who was Resident 1's assigned nurse for that shift, dated March 1, 2025, at 3:50 PM, that noted Resident 1 had increased weakness, pain medicine not effective after administering her as needed oxycodone and Tylenol, her blood pressure was low, Resident 1's son was visiting and requesting her to be sent to the hospital for evaluation and treatment, the nurse practitioner was made aware, and the ambulance arrived at 3:50 PM.</p> <p>Review of Resident 1's progress notes revealed a note written by Employee 8 dated March 1, 2025, at 9:00 PM, that indicated Resident 1 had been admitted to the hospital with diagnoses of septic shock (life threatening condition caused by a severe localized or system-wide infection that requires immediate medical attention), acute kidney injury (an abrupt disruption in kidney function), and a urinary tract infection.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility provided incident report documentation revealed that Resident 1's son contacted the facility and reported concerns regarding Employee 5's (Agency RN Supervisor) actions and Resident 1's care on March 1, 2025. The son notified Employee 5 of Resident 1's change in condition and requested that she be sent to the hospital, Employee 5 rolled her eyes and stated that Resident 1 did not need to go to the hospital.</p> <p>Review of facility provided incident report documentation revealed a statement written by Employee 5 dated March 10, 2025, that indicated she was unaware of any situation or incident involving Resident 1 on March 1, 2025.</p> <p>Further review of Resident 1's progress notes failed to reveal any documentation that Employee 5 completed a nursing assessment of Resident 1 when she was notified of the change in her condition, or that Resident 1's physician was made aware of the changes at time they were initially noted.</p> <p>Review of facility provided incident report documentation revealed a statement written by Employee 6, undated, that Resident 1's son had approached her about his mother's condition as he thought something was off and that she seemed worse than she was 2 weeks ago. Employee 6 indicated that she did tell Resident 1's son that she had administered a narcotic pain medication about an hour prior and that she had also just administered Tylenol right before his arrival. Employee 6 notified Employee 5 of Resident's son's request. Employee 6 indicated that she overheard Employee 5 tell Resident 1's son she had no clinical indications to send her to the hospital.</p> <p>Further review of the incident report revealed a statement written by Employee 8, dated March 7, 2025, that indicated on March 1, 2025, she arrived on the nursing unit at approximately 3:15 PM. Employee 8 said she greeted Employee 5 who was leaving the nursing station. Employee 7 indicated that Employee 5 told her that there was not much going on in the building except a lady wanting to go to the hospital. Employee 8 indicated that she spoke to Employees 6 and 7, and Employee 7 told her that Resident 1's blood pressure was 78/40 and that she was experiencing a change in mental status. Employee 8 indicated that she immediately began calling 911.</p> <p>Review of Resident 1's hospital records revealed that she arrived at the emergency room on March 1, 2025, at 4:20 PM, and that she had a temperature of 86.9 degrees Fahrenheit, a pulse rate of 44, a respiratory rate of 27 per minute (normal 16-20 per minute), a blood pressure of 79/43, and an oxygen saturation of 87% on 10 liters of oxygen. She was noted to be in acute distress, mildly confused, very fatigued and lethargic, and able to move all extremities with generalized weakness noted.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and Employee 1 (RN) on March 20, 2025, at 10:50 AM, the NHA indicated that she was not comfortable stating whether Employee 5 should have sent Resident 1 to the hospital when the Resident and her son requested since she was not present to visualize Resident 1's status. When asked if Employee 6 should have notified Resident 1's physician and sent her to the hospital as requested by Resident 1 and her son, the NHA indicated that Employee 6 had followed the chain of command.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident 5's clinical record revealed diagnoses that included 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 left non-dominant side, Type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and severe protein-calorie malnutrition (malnutrition caused when not enough proteins and calories are consumed).</p> <p>Review of Resident 5's clinical record progress notes revealed a note written by a LPN dated March 9, 2025, at 10:05 PM, that indicated Resident 5 had refused her medications and had multiple episodes of nausea and vomiting on evening shift.</p> <p>Review of Resident 5's clinical record progress notes revealed a note written by a LPN dated March 10, 2025, at 10:50 AM, that indicated Resident 5 had refused her medications and was complaining of feeling nauseous.</p> <p>Review of Resident 5's clinical record progress notes revealed a note written by a LPN dated March 10, 2025, at 4:59 PM, that indicated Resident 5 had refused her medications and was complaining of general malaise (a general feeling of being ill or having no energy which can be an indefinite feeling of debility or discomfort, or a sign of an illness).</p> <p>Review of Resident 5's physician orders failed to reveal any medication orders to treat her nausea or vomiting.</p> <p>Review of Resident 5's meal intakes revealed that no meal intakes were documented after March 9, 2025, at 4:30 PM.</p> <p>Further review of Resident 5's clinical failed to reveal any documentation that the LPNs had notified a RN of Resident 5's refusal of medications, nausea, vomiting, and malaise; that Resident 5 was assessed by a RN; or that Resident 5's physician was made aware of her nausea, vomiting, malaise, and medication refusals.</p> <p>During a staff interview with the NHA and Employee 1 on March 20, 2025, at 10:50 AM, Employee 1 indicated that the LPNs should have notified a RN of Resident 5's condition, and a RN should have completed an assessment and notified the physician as applicable.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on facility policy review, clinical record review, facility incident report investigation review, facility training records, and staff interview, it was determined that the facility failed to ensure that residents received adequate assistance to prevent accidents, which resulted in harm as evidenced by displaced hardware securing a fracture for one of two residents reviewed for falls (Resident 3).</p> <p>Findings include:</p> <p>Review of facility policy, titled NSG215 Falls Management, with a last revised date of March 15, 2024, revealed Interventions to reduce risk and minimize injury will be implemented as appropriate; and 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care.</p> <p>Review of Resident 3's clinical record revealed diagnoses that included chronic kidney disease (longstanding disease of the kidneys leading to renal failure), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart), and history of falling.</p> <p>Review of Resident 3's care plan revealed an intervention for provide resident/patient with extensive assist of 2 for bed mobility, dated March 12, 2024.</p> <p>Review of Resident 3's clinical record progress notes revealed a note dated March 15, 2025, at 7:46 AM, that indicated around 5:40 AM the Resident was noted to be on the floor, was complaining of left knee pain, right hip pain, and worsening left arm pain. The Resident rated all her pain 10/10, unable to move lower extremities and left arm, and the left knee warm to touch. The note indicated that Resident 3's provider was made aware and orders were given for x-rays of both hips, pelvis, both knees, and left forearm; as well as orders for an additional pain medication and to hold their anticoagulant (blood thinning) medication for two days. The note further indicated that Employee 4 (Agency Nurse Aide) said she was trying to change resident when she rolled out the opposite side of bed and landed with her feet touching the ground first.</p> <p>Further review of Resident 3's clinical record progress notes revealed a note dated March 15, 2025, at 12:04 PM, that the x-ray revealed an appliance in Resident 3's left arm with an abnormality noted. The note further indicated that Resident 3's provider was made aware and an order was given to transport Resident 3 to the hospital.</p> <p>Further review of Resident 3's clinical record progress notes revealed a note dated March 15, 2025, at 3:46 PM, that indicated Resident 3 was admitted to the hospital with a displaced fracture of left humerus.</p> <p>Review of Resident 3's x-ray report dated March 15, 2025, revealed that there was a sideplate and screws bridging a distal humerus fracture. A screw in the side plate is broken and the distal portion of the sideplate is no longer attached to the humerus.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility provided investigation witness statement from Employee 4 dated March 15, 2025, revealed that Employee 4 indicated she was providing care, and she had Resident 3 on her side but she rolled off; I grabbed her, but she still fell.</p> <p>Review of facility provided investigation witness statement from Resident 3 dated March 15, 2025, revealed that Employee 4 had pushed her too hard and she fell out of the bed. Resident 3 further indicated that the bed was in high position and that Employee 4 had kept pulling the sheets and the Resident got closer to the edge of the bed and slid out of the bed, onto the floor.</p> <p>Review of facility provided investigation witness statement from Resident 4, the roommate of Resident 3, dated March 15, 2025, indicated that Resident 4's bed was in the high position and although Resident 4 did not see Resident 3 fall; she heard her fall.</p> <p>Review of facility provided investigation information confirmed that Employee 4 was providing care and turning and repositioning alone and that she had rolled Resident 3 away from her, resulting in Resident 3 rolling out of bed onto the floor.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and Employee 1 on March 20, 2025, at 10:51 AM, the NHA confirmed that she would expect staff to follow a resident's care plan and follow proper care techniques to prevent accidents.</p> <p>201.4(a) Responsibility of licensee</p> <p>201.18(b)(1)(e)(1) Management</p> <p>211.10(c)(d) Resident care policies</p> <p>211.12(d)(1)(2)(5) Nursing services</p> | | |