STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395733	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gettysburg Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, review of facility policy, and staff interviews, it was determined that the facility failed to obtain a physician's order for the use of a restraint following application of an emergency restraint for one of one individuals reviewed for restraint use (Resident 4).Findings include:Review of facility policy, Restraints: Use of, revised June 15, 2022, revealed, Emergency restraints may be used: As a last resort to protect the safety of the patient and others if patient's unanticipated violent or aggressive behavior places self or others in imminent danger. The order for the use of the restraint must be obtained from the physician/advanced practice provider either during the application of the restraint or immediately after the restraint has been applied. Supporting documentation must reflect what the patient was doing and what happened that presented the imminent danger.Review of Resident 4's clinical record revealed diagnoses that included Parkinson's Disease (movement disorder of the nervous system that worsens over time) and dementia, severe with psychotic disturbance (decline in cognitive functioning that affects memory, thinking and social abilities, significantly interfering with everyday life).Review of Resident 4's nursing progress note dated August 11, 2025, revealed, Called toward room, in hallway, by [nurse aide] in hall stating 'the patient is going to hit the girl in this room.' Upon entering room, patient was being asked to sit down in chair at bedside and began striking out at Staff. Patient continued growing more agitated with staff despite quiet verbal redirection and patience offered. This writer intervened to deflect patient's aggressive advances toward staff and protect patient with the assistance of two others. Patient fighting against chair, proceeded to try scratching, gripping, head butting and biting at those in his vicinity. Staff preserved safety to the patient and their peers despite the aggressive and violent outbursts. Patient verbalizing threats towards Staff and demand he be released from position. Educated patient on steps needed to release from position however, patient persistently posturing with flat affect, lacking insight, and judgment while thrashing.Respirations and pulse slightly elevated due to agitation, patient shows no signs or symptoms of distress. Circulation and skin integrity monitored throughout interaction without deviation from baseline.While interaction was taking place, supervisory staff stepped in to call for outside help. EMS [Emergency Medical Services] was contacted via 911. EMS arrived on scene to survey situation and upon seeing patient's aggression, called for assistance from state police. Wife entered room and offered to help facilitate de-escalation, paramedics told her to stay back for safety. When [State Police] arrived on scene, background of the situation was relayed to officers, and intramuscular ketamine [anesthetic] was administered by paramedic to patient's left thigh. Staff was cycled slowly to be replaced by officers and paramedics to facilitate ease of transfer to stretcher. Upon patient's exit from the unit, one on one processing and active listening provided to patient's wife at bedside. Review of Employee 7's (Nurse Aide) witness statement dated August 11, 2025, revealed, in part, I was called to assist fellow CNA [certified nurse aide] with [Resident 4]. When walking [Resident 4] was already irritable and not following commands when I went closer to him he then lunged forward pinning me on to the bed. Fellow CNA called for help [Resident 4] still wasn't following commands and still was very aggressive . no way to console him or de-escalate. Employee 7 was helping to hold his knees down until Employee 2 [Registered Nurse] came in.Review of Employee 9's (Nurse Aide) witness statement dated August 11, 2025, revealed, in part, [Resident 4] was getting up from his bed. I assisted him by bringing his wheelchair, but he wouldn't sit down. The nurse was walking past and I asked her for help but one of the aides came in to help assist as we told [Resident 4] to have a seat in his chair cause we didn't want him to fall. He pushed the other aide down to this bed and held her down. We tried to tell him we were there to help but he kept holding her down to the bed .Nurse and aides came to assist but he became aggressive.Review of Employee 10's (Registered Nurse) witness statement dated August 11, 2025, revealed, in part, I was alerted by CNA screaming down the A hall that they needed help with [Resident 4]. I go in the room and see [Resident 4] pinning one of the CNAs on the bed. As another aide attempts to take him off her, but as she tries to get him off her he tries to throw punches at them. We attempted to get him to sit on the chair, but he continued to throw punches and kick with both legs at all staff members. As he continues his aggression I call [practitioner] and get order to send to ER [Emergency Room]. When Employee 10 entered room [Employee 8 (Nurse Aide)] had Resident's left wrist. [Employee 13 (Licensed Practical Nurse)] had right wrist. They sat him down on chair. He began kicking staff so Employee 2 was holding his right thigh down to keep him from kicking.Review of Employee 11's (Licensed Practical Nurse) witness statement dated August 11, 2025, revealed, in part, I was down C Hall when [Employee 9] came down the hall stating they need help with

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, facility documents, and resident and staff interviews, it was determined the facility failed to ensure that residents were free from any significant medication errors for one of four residents reviewed (Resident 1). Findings include:Review of facility policy, Medication Administration last revised January 2025, stated, medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only by persons legally authorized to do so. # 9. The individual administering medications verifies medication is correct three (3) times before administering the medication.When pulling the medication package from med cart.When dose is prepared.Before dose is administered.# 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include: a. Check identification band. b. Check attached to medical record photograph. c. Verify resident identification with other nursing care center personnel.Note: the resident's room number or physical location is not used as an identifier.Review of the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included hypertension (elevated blood pressure) and dysphagia (difficulty swallowing).Review of Resident 1's quarterly MDS (minimum data set- standardized assessment tool to gather comprehensive information about residents' functional capabilities, health status, and care needs) completed May 5, 2025, revealed a BIMS (brief interview of mental status) of 15, indicating intact cognition.Review of a select documents revealed Resident 1 reported to her daughter that Employee 1 (Registered Nurse) on July 31, 2025, at 2:00 AM, entered her room, where she resides with her spouse who is hospice status. Resident 1 said she was asleep, and Employee 1 placed a syringe in the corner of her mouth. Resident 1 immediately woke up and said no, no, no that is my husband's medication. Resident 1 reported that she was able to taste some of the medication before the syringe was removed. Resident 1 reported that Employee 1 pulled the syringe out of her mouth, turned around, and inserted the same syringe into her husband's mouth and administered the Morphine (opioid). Resident 1 reported the event to nursing on July 31, 2025, at 7:00 AM. Resident 1 notified her daughter in the evening of the event on July 31, 2025.Resident 1 was interviewed by Employee 2 (Registered Nurse) on July 31, 2025, at 9:30 AM, after Employee 12 (Registered Nurse) informed her that Resident 1 needs to talk with her because the night shift nurse tried to give her husband's liquid medication. Resident 1 was interviewed again on August 1, 2025, after family of Resident 1 came to the nurse's station and questioned Employee 2 why their mother received their dad's medication and what was being done about it. Employee 2 informed the family that she didn't realize the syringe went into her mouth when she interviewed Resident 1 on July 31, 2025. Employee 2 reported to the Director of Nursing (DON) on August 1, 2025, after interviewing Resident 1 for more details about the syringe and it being placed in her mouth. The DON completed an Individual Performance Improvement Plan on August 1, 2025, and had Employee 1 sign it. The form is marked Unsatisfactory Job Performance.This Surveyor interviewed Resident 1 on August 13, 2025, at 11:00 AM, and requested that she review the event that occurred on July 31, 2025. Resident 1 stated that she was awoken on July 31, 2025, at 2:00 AM, by a syringe being placed in the corner of her mouth by Employee 1, a male nurse. She said she yelled no, no, no that's my husband's medication. Resident 1 added that her husband receives liquid Morphine every 4 hours with a syringe for his hospice care. Resident 1 confirmed that she was able to taste some of the medication. Resident 1 said the nurse removed the syringe from her mouth and immediately turned toward her husband in the next bed and administered the medication to her husband with the same syringe. Resident 1 was asked if she reported the event and she said she reported that morning about 7:00 AM, because no one approached her about the event. Resident 1 said she wasn't sure if it was reported by the male nurse. Resident said staff took her blood pressure on July 31, 2025, at 10:30 AM, and it was 100/60, (confirmed in clinical record) which was low per Resident 1. Resident 1 added that she didn't urinate for about 6-8 hours, which she said was unusual for her, but denied any pelvic pressure. (Note: a side effect of morphine is urinary retention and reduced arterial blood pressure). Resident 1 said was able to attend activities and had no complaints of discomfort. During an interview with Resident 1's daughter on August 13, 2025, at 11:15 AM, the daughter stated that she was never notified about the event until Resident 1 called and informed her in the evening on July 31, 2025.During an interview with the Nursing Home Administrator (NHA) on August 13, 2025, at 11:45 AM, she confirmed that Employee 1 never reported the medication error with Resident 1. A statement written August

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, clinical record review, as well as resident, resident family member, and staff interviews, it was determined that the facility failed to maintain professional practices that support infection prevention and control for one of four residents reviewed (Resident 1).Findings include: A review of the facility policy, titled Infection Control Policies and Procedures, last revised February 24, 2025, stated, Centers will record incidents identified under the Infection Prevention and Control Program (IPCP) and the corrective actions taken. Breaches in Practice are failures in infection control practices, such as non-compliance.Reports from staff, patients, or families on any healthcare associated infection or spread of disease due to possible errors in infection prevention or control Centers for Disease Control states all single-dose syringes should never be used for more than one patient and is a breach in practice.Review of the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included hypertension (elevated blood pressure) and dysphagia (difficulty swallowing).Review of Resident 1's quarterly MDS (minimum data set-standardized assessment tool to gather comprehensive information about residents' functional capabilities, health status, and care needs) completed May 5, 2025, revealed a BIMS (brief interview of mental status) of 15, indicating intact cognition.Review of select documents revealed Resident 1 reported to her daughter that Employee 1 (Registered Nurse) on July 31, 2025, at 2:00 AM, entered her room, where she resides with her spouse who is hospice status. Resident 1 said she was asleep, and Employee 1 placed a syringe in the corner of her mouth. Resident 1 immediately woke up and said no, no, no that is my husband's medication. Resident 1 reported that she was able to taste some of the medication before the syringe was removed. Resident 1 reported that Employee 1 pulled the syringe out of her mouth, turned around, and inserted the same syringe into her husband's mouth and administered the Morphine (opioid).Resident 1 reported the event to nursing on July 31, 2025, at 7:00 AM. Resident 1 notified her daughter in the evening of the event on July 31, 2025.During an interview with Resident 1's daughter on August 13, 2025, at 11:15 AM, the daughter stated that she was never notified about the event until Resident 1 called and informed her in the evening on July 31, 2025. Resident 1's daughter was also concerned about the syringe being placed in her dad's mouth due to a current infection Resident 1 was receiving antibiotics to treat.A review of Resident 1's clinical record revealed the Resident was diagnosed with bacterial sinusitis and was currently receiving Cefuroxime Axetil (antibiotic that treats bacterial infections) 500 milligrams twice a day for 7 days, effective July 29, 2025.During an interview with the Nursing Home Administrator (NHA) on August 13, 2025, at approximately 1:00 PM, the NHA agreed that the syringe should have been discarded after being inserted into Resident 1's mouth and the event should have been reported by Employee 1. The NHA added that Employee 1 no longer works at the facility.28 Pa Code: 201.18 (b)(1)(3) Management28 Pa Code: 211.10 (d) Resident care policies