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	04/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility investigation documentation, review of hospital documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure each resident the right to be free from neglect for one of four residents reviewed (Resident 1), which resulted in actual harm for Resident 1 as evidenced by a closed fracture of left hip.Findings include: Review of facility policy, titled Abuse Prohibition last reviewed on November 14, 2025, read, in part, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation of all residents. 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. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information between Center staff, patient, practitioners, and patient representatives. Review of Resident 1's clinical record revealed diagnoses that included abnormalities of gait and mobility (unusual patterns of walking or movement), and history of falling. Review of Resident 1's comprehensive care plan revealed a focus area for Resident requires assistance/is dependent for activities of daily living care, with an intervention for Transfers with assist of two and FWW (front-wheeled walker), with a start date of June 21, 2024. Review of Resident 1's Kardex (nurse aid reference for resident information) stated Transfers with assist of two and FWW, with a start date of June 21, 2024. Review of Resident 1's clinical record revealed a nursing progress note on April 14, 2026, that read, in part, Resident was found sitting on the floor on her buttocks, complained of excruciating pain and unable to move her left leg. Resident stated she could not handle her weight while holding on to the nightstand as usual and she lost her balance and sat on the floor. Resident complaining of left hip excruciating pain, resident is unable to move the leg. Certified Registered Nurse Practitioner notified and advised that we send resident to the ER. Review of facility investigation revealed [Resident 1] was being provided incontinence care by [Employee 1 (Nurse Aide)] while standing and holding on to her nightstand as she typically does. She was wearing non-skid socks on her feet. Her legs became weak and she sustained a fall on her buttocks. [Resident 1] did not hit her head. Review of statement written by the Nursing Home Administrator (NHA) on April 15, 2026, titled Roommate Statement revealed Interviewed [Resident 2] regarding [Resident 1's] fall last evening. She stated she was in the room at the time of [Resident 1's] fall. She reported that one aide transferred [Resident 1] at bedtime and she fell. Review of email correspondence of statement written by Employee 1 read, in part, I assisted [Resident 1] to stand beside the nightstand in order to change her brief and help her into bed. Immediately after removing her soiled brief, I attempted to dispose of it in the trash behind me. Before I could fully react, the resident began to fall backward. I was unable to catch her in time, and she landed on her buttocks. She began expressing pain shortly after. Review of Resident 1's transfer nurse aide task read Transfers with assist of two and FWW further review revealed the task was signed yes by Employee 1 to indicate two people assisted with Resident 1's transfer the evening of (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

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	04/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	her fall on April 14, 2026, despite his statement that he transferred her from her chair to her nightstand by himself. Further review of Resident 1's transfer nurse aide task revealed that Employee 1 cared for Resident 1 on April 6 and 7, 2026, and signed that the Resident 1 required an assist of two and FWW and the task was marked as completed. Review of Resident 1's hospital paperwork revealed she was admitted to the hospital on [DATE], following a fall resulting in a closed left hip fracture. The Resident had a surgical repair to her hip on April 15, 2026, and was discharged back to the facility on April 19, 2026. Interview with the NHA on April 22, 2026, at 10:54 AM, she revealed she would expect residents to be transferred per their proper transfer status. During an onsite visit on April 22, 2026, at 10:17 AM, the NHA provided the facility's plan of correction that was put into place as a result of the facility's investigation into the fall. QAPI met on April 15, 2026, to review the incident and develop an immediate plan of action, which included the following: Provider/Responsible party notification- 4/14/26Investigation initiated- 4/14/26NA placed on administrative leave during investigation- 4/14/26Staff re-educated on abuse prohibition- 4/15/26Staff re-educated on sate resident handling/transfer equipment- 4/15/26Nursing staff re-educated on Sate Resident Handing Program 4/15/26An initial audit of current residents conducted to ensure current transfer status is accurate and included in the care plan and Kardex- 4/15/26Re-educate NAs, including agency on checking residents Kardex prior to start of shift 4/15/26DON (Director of Nursing)/designee to complete an audit of agency NA (Nurse Aide) orientation to validate completion- 4/16/26 Review of the Plan of correction revealed an initial audit was completed for all residents on April 15, 2026, to ensure current transfer status is included in the care plan and Kardex (care guide), weekly audits were conducted to ensure five randomly selected residents current transfer status were accurate and included in the care plan and Kardex, and weekly audits were conducted to ensure nursing staff were performing transfers properly per their assessments, as per their corrective action plan. In addition, a weekly audit was completed to ensure all contracted nursing staff had received orientation to the facility to validate completion. During an interview with the NHA on April 22, 2026, at 11:42 AM, she revealed that contracted nursing staff are supposed to receive a packet for orientation to the facility that includes a center tour and general information, policies and procedures (including safe resident handling), and various other pertinent information. The packet is signed by the contracted staff before the start of their first shift. She further revealed the audit indicated that eight out of 13 new contracted staff did not receive the education prior to their shift; Employee 1 was on the list that he did not complete orientation. Prior to the abbreviated survey, the facility failed to ensure each resident the right to be free from neglect, resulting in harm for Resident 1 as evidenced by a closed fracture of left hip. The facility's plan of correction was reviewed during the survey. Review of facility documentation revealed that on April 16, 2026, the facility had completed education for staff and audits to ensure compliance. During the abbreviated survey on April 22, 2026, staff interviews, resident interviews, resident record review, and observations revealed no concerns with neglect. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management

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	04/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility investigation documentation, review of hospital documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure that each resident receives adequate supervision and assistance to prevent accidents based on individual needs for one of four resident's reviewed (Resident 1), which resulted in actual harm for Resident 1 as evidenced by a closed fracture of left hip. Findings include: Review of facility policy, titled Safe Resident Handling/Transfer Equipment last revised January 15, 2026, read, in part, Safe Resident Handling involves the use of assistive devices to ensure that patients can be transferred safely and that care providers avoid performing high risk patient handling tasks. Staff will complete training and demonstrate competency in the use of safe resident handling equipment. Review of Resident 1's clinical record revealed diagnoses that included fracture of unspecified part of neck of left femur, abnormalities of gait and mobility (unusual patterns of walking or movement), and history of falling. Review of Resident 1's comprehensive care plan revealed a focus area for Resident requires assistance/is dependent for activities of daily living care, with an intervention for Transfers with assist of two and FWW (front-wheeled walker) with a start date of June 21, 2024. Review of Resident 1's Kardex (nurse aid reference for resident information) stated Transfers with assist of two and FWW, with a start date of June 21, 2024. Review of Resident 1's clinical record revealed a nursing progress note on April 14, 2026, that read, in part, Resident was found sitting on the floor on her buttocks. Resident stated she could not handle her weight while holding on to the nightstand as usual and she lost her balance and sat on the floor. Resident complaining of left hip excruciating pain, resident is unable to move the leg. Certified Registered Nurse Practitioner notified and advised that we send residents to the ER. Review of facility investigation revealed [Resident 1] was being provided incontinence care by [Employee 1 (Nurse Aide)] while standing and holding on to her night stand as she typically does. She was wearing non-skid socks on her feet. Her legs became weak and she sustained a fall on her buttocks. [Resident 1] did not hit her head. Review of statement written by the Nursing Home Administrator (NHA) on April 15, 2026, titled Roommate Statement revealed Interviewed [Resident 2] regarding [Resident 1's] fall last evening. She stated she was in the room at the time of [Resident 1's] fall. She reported that one aide transferred [Resident 1] at bedtime and she fell. Review of email correspondence of statement written by Employee 1 read, in part, I assisted [Resident 1] to stand beside the nightstand in order to change her brief and help her into bed. Immediately after removing her soiled brief, I attempted to dispose of it in the trash behind me. Before I could fully react, the resident began to fall backward. I was unable to catch her in time, and she landed on her buttocks. She began expressing pain shortly after. Review of Resident 1's transfer nurse aide task read Transfers with assist of two and FWW further review revealed the task was signed yes by Employee 1 to indicate two people assisted with Resident 1's transfer the evening of her fall on April 14, 2026, despite his statement that he transferred her from her chair to her nightstand by himself. Review of Resident 1's hospital paperwork revealed she was admitted to the hospital on [DATE], following a fall resulting in a closed left hip fracture. The Resident had a surgical repair to her hip on April 15, 2026, and she was discharged back to the facility on April 19, 2026. Interview with the NHA on April 22, 2026, at 10:54 AM, she revealed she would expect residents to be transferred per their proper transfer status. During an onsite visit on April 22, 2026, at 10:17 AM, the NHA provided the facility's plan of correction that was put into place as a result of the facility's investigation into the fall. QAPI met on April 15, 2026, to review the incident and develop an immediate plan of action, which included the following: Provider/Responsible party notification- 4/14/26Investigation initiated- 4/14/26NA (Nurse Aide) placed on administrative leave during investigation- 4/14/26Staff re-educated on abuse prohibition- (continued on next page)

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	04/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	4/15/26Staff re-educated on sate resident handling/transfer equipment- 4/15/26Nursing staff re-educated on Sate Resident Handing Program 4/15/26An initial audit of current residents conducted to ensure current transfer status is accurate and included in the care plan and Kardex- 4/15/26Re-educate NAs, including agency on checking residents Kardex prior to start of shift 4/15/26DON (Director of Nursing)/designee to complete an audit of agency NA orientation to validate completion- 4/16/26 Review of the Plan of correction revealed an initial audit was completed for all residents on April 15, 2026, to ensure current transfer status is included in the care plan and Kardex (care guide), weekly audits were conducted to ensure five randomly selected residents current transfer status were accurate and included in the care plan and Kardex, and weekly audits were conducted to ensure nursing staff were performing transfers properly per their assessments, as per their corrective action plan. In addition, a weekly audit was completed to ensure all contracted nursing staff had received orientation to the facility to validate completion. During an interview with the NHA on April 22, 2026, at 11:42 AM, she revealed that contracted nursing staff are supposed to receive a packet for orientation to the facility that includes a center tour and general information, policies and procedures (including safe resident handling), and various other pertinent information. The packet is signed by the contracted staff before the start of their first shift. She further revealed the audit indicated that eight out of 13 new contracted staff did not receive the education prior to their shift; Employee 1 was on the list that he did not complete orientation. Prior to the abbreviated survey, the facility failed to ensure each resident the right to be free from neglect, resulting in harm for Resident 1 as evidenced by a closed fracture of left hip. The facility's plan of correction was reviewed during the survey. Review of facility documentation revealed that on April 16, 2026, the facility had completed education for staff and audits to ensure compliance. During the abbreviated survey on April 22, 2026, staff interviews, resident interviews, resident record review, and observations revealed no concerns with falls or staff using the correct transfer status. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management