

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record reviews, review of select facility documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to revise a resident's care plan to provide adequate supervision with eating for one of four residents reviewed (Resident 4), which resulted in actual harm as evidenced by Resident 4 choking and suffering death. Findings include: Review of facility policy titled OPS416 Person-Centered Care Plan, dated September 15, 2025, revealed, in part, 6. Care plans will be 6.1 Communicated to appropriate staff, patient, representative, family; 6.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. Review of Resident 4's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), cognitive communication deficit (a group of disorders that affect a person's ability to communicate which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions), and need for assistance with personal care. Review of Resident 4's physician orders revealed an order for a regular texture liberalized diet and standard thin liquids consistency. Supervision and out of bed for all regular texture meals and snacks dated May 8, 2026. Review of Resident 4's Speech Therapy Discharge summary dated [DATE], indicated section titled Discharge Recommendations and Status that it is recommended the patient use the following strategies during oral intake: rate modification, bolus size modification, solid/liquid alternation, sitting upright and out of bed. SLP (Speech Language Pathologist) recommends patient is supervised during all meals for safety. Pt is discharged on a regular texture diet with thin liquids. Review of Resident 4's care plan failed to reveal any interventions that he was to be supervised with meals or snacks or the specific strategies to utilize as indicated in his Speech Therapy Discharge Summary. Further review of Resident 4's clinical record progress notes revealed a nurses note written by Employee 8 (Registered Nurse) dated June 4, 2026, at 5:30 PM, which indicated Employee 8 was summoned to one of the dining areas due to a resident having an emergency and upon entering Employee 8 observed Resident 4's face and neck to be light blue in color and unresponsive. Nursing staff rendering CPR. The note further indicated that Employee 8 attempted to administer artificial breaths four times and attempted to clear Resident 4's mouth of undigested food unsuccessfully. The note further indicated that Emergency Medical Services arrived at the facility and after they received report from Employee 8, they contacted their medical command physician who directed that resuscitation efforts be stopped. Resident 4 was pronounced deceased at 5:45 PM. Review of facility provided witness statements for Resident 4's choking incident revealed a statement from Employee 9 (Nurse Aide) which indicated that on June 4, 2026, at approximately 5:15 PM, she was assisting another resident with his meal, and that Resident 4 was seated beside her in his wheelchair eating his meal. She indicated that she then left the dining room to assist in passing trays in a hallway and that Resident 4 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395733	Facility ID: 395733 If continuation sheet Page 1 of 5

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F 0657 Level of Harm - Actual harm Residents Affected - Few	was fine when she left. Employee 9's statement then indicated that she was away less than ten minutes when she heard someone yelling Help! Review of facility provided plan to correct the identified issue revealed the following:1) Quality Assurance Performance Improvement committee was held on June 5, 2026, to review event and develop correction plan.2) DON/designee to conduct initial audit of all residents who require supervision with meals per Speech Therapy to confirm staff are providing supervision and care plan matches which was completed June 8, 2026.3) Nursing staff educated on signs and symptoms of choking; identification of residents in need of eating in supervised areas; sub-dining rooms need to be supervised during meals and nursing staff are to remain until last tray has been collected completed June 5-6, 2026.4) DON/designee will conduct an audit of all dining rooms to ensure staff supervision during meals weekly for four weeks then monthly for two months.5) Ongoing audit results will be monitored through the Quality Assurance Performance Improvement committee for further review and recommendations.6) Compliance date June 8, 2026. Random interviews with five nurses and three nurse aides on June 11, 2026, revealed they were provided with written and verbal education and signed the Employee Training Sign-In Sheets. Observation of lunch meal on June 11, 2026, between 12:25 PM and 1:20 PM, revealed at least one nursing staff member was always present during the meal. During a staff interview with the Nursing Home Administrator on June 11, 2026, at 2:22 PM, she confirmed that Resident 4 was left unsupervised while eating and choked. During a staff interview with Employee 8 on June 11, 2026, at 2:45 PM, he indicated that Resident 4 had received the correct meal which was a regular diet with thin liquids. Employee 8 also confirmed that Resident 8 was unsupervised in the dining room when the choking incident occurred. During a final staff interview with the NHA and Director of Nursing on June 11, 2026, at 2:50 PM, the NHA acknowledged that Resident 4's care plan was not revised to include the Speech Therapy recommendations which included supervision at all times when eating. She stated, It was in his orders. The facility failed to revise Resident 4's care plan. The resident was not supervised while eating which resulted in actual harm of a choking incident resulting in death. 201.4(a) Responsibility of licensee.201.18(b)(1)(3) Management.211.10(d) Resident care policies.211.12(d)(1)(2)(3)(5) Nursing services.		

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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 select facility documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide adequate supervision to prevent accidents with eating for one of four residents reviewed (Resident 4), which resulted in actual harm as evidenced by Resident 4 choking and suffering death. Findings include: Review of facility policy, titled NSG107 Emergency: Medical Response, dated November 14, 2025, revealed, in part, Response to medical emergencies will be acted upon within the scope of practice of the licensed nursing staff. The employee who first witnesses or is first on-site of a medical emergency, that is trained, will initiate immediate action including cardiopulmonary resuscitation (CPR) as appropriate, basic first aid, and summon for assistance. A licensed nurse will assume the role of the Medical Emergency Leader until the arrival of advanced medical personnel (e.g., Emergency Medical Services (EMS)/Paramedics), ensuring all actions are guided by current clinical standards, physician/provider orders (including advanced directives/code status), and Center protocols. Review of Resident 4's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), cognitive communication deficit (a group of disorders that affect a person's ability to communicate which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions), and need for assistance with personal care. Review of Resident 4's physician orders revealed an order for a regular texture liberalized diet and standard thin liquids consistency. Supervision and out of bed for all regular texture meals and snacks, dated May 8, 2026; and Do Not Resuscitate/Full Treatment, dated April 22, 2026. Review of Resident 4's Speech Therapy Treatment Encounter Note dated May 7, 2026, revealed that Resident 4 attempted to eat the tea bag from his mug while being supervised by the Speech Therapist. The Speech Therapist educated Resident 4 that they were not intended to be eaten. Review of Resident 4's Speech Therapy Treatment Encounter Note dated May 8, 2026, revealed that Resident 4's diet was upgraded to regular texture with thin liquids. He must be supervised and out of bed for all regular texture meals and snacks. Review of Resident 4's Speech Therapy Treatment Encounter Note dated May 11, 2026, revealed that Resident 4 required verbal prompting to alternate solids and liquids. Review of Resident 4's Speech Therapy Treatment Encounter Note dated May 12, 2026, revealed that Resident 4 needed multiple cues and reminders to initiate eating and became easily distracted by external visual and auditory stimuli. Review of Resident 4's Speech Therapy Discharge summary dated [DATE], indicated section titled Discharge Recommendations and Status that it is recommended the patient use the following strategies during oral intake: rate modification, bolus size modification, solid/liquid alternation, sitting upright and out of bed. SLP (Speech Language Pathologist) recommends patient is supervised during all meals for safety. Pt is discharged on a regular texture diet with thin liquids. Further review of Resident 4's clinical record progress notes revealed a nurse's note written by Employee 8 (Registered Nurse) dated June 4, 2026, at 5:30 PM, which indicated Employee 8 was summoned to one of the dining areas due to a resident having an emergency and, upon entering, Employee 8 observed Resident 4's face and neck to be light blue in color and unresponsive. Nursing staff rendering CPR. The note further indicated that Employee 8 attempted to administer artificial breaths four times and attempted to clear Resident 4's mouth of undigested food unsuccessfully. The note further indicated that Emergency Medical Services arrived at the facility and after they received report from Employee 8, they contacted their medical command physician who directed that resuscitation efforts be stopped. Resident 4 was pronounced deceased at 5:45 PM. Review of facility provided incident report for (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 4 dated June 4, 2026, at 5:25 PM, indicated that at approximately 5:25 PM, a nurse aide heard a yell for help from the South Sub-dining room. When the nurse aide ran back to the dining room, she saw Resident 4 sliding out of his wheelchair and hitting the back of his head on the floor before she could reach him. The report further indicated that when the nurse aide reached Resident 4, she observed him to be unresponsive with blue lips. This nurse aide was later identified as Employee 9. Review of facility provided witness statements for Resident 4's choking incident revealed a statement from Employee 8 (Registered Nurse Supervisor), undated, which indicated that he was summoned to the South sub-dining room for a resident emergency. He said that when he arrived Resident 4 was light blue in color in his face and across his neck on the floor of the dining room unresponsive. Employee 8's statement further indicated that another Registered Nurse was giving CPR compressions, and that when the AED was applied it advised no shock, advised continue CPR. Employee 8 then obtained a bag-valve-mask (a hand-held device commonly used to provide ventilation to patients who are not breathing or not breathing adequately) and started to provide artificial respirations but was unsuccessful. Employee 8 then repositioned Resident 4 and tried again with no success. Employee 8 then assessed Resident 4's mouth and found thick undigested rice and meat. Employee 8 again attempted to provide artificial respirations without success. Employee 8 was relieved by Employee 10 (Licensed Practical Nurse) to provide airway management while Employee 8 prepared paperwork for emergent transfer. Employee 8's statement indicated that Emergency Medical Services arrived at 5:44 PM and they notified their Medical Commander who directed that resuscitation efforts be stopped. Resident 4 was pronounced deceased at 5:45 PM. Review of facility provided witness statements for Resident 4's choking incident revealed a statement from Employee 9 (Nurse Aide) which indicated that on June 4, 2026, at approximately 5:15 PM, she was assisting another resident with his meal, and that Resident 4 was seated beside her in his wheelchair eating his meal. She indicated that she then left the dining room to assist in passing trays in a hallway and that Resident 4 was fine when she left. Employee 9's statement then indicated that she was away less than 10 minutes when she heard someone yelling Help! Help! Employee 9 indicated that she ran back to the dining room, and she saw Resident 4 slide off his wheelchair backwards onto the floor, hitting the back of his head. Employee 9 indicated that she ran over to Resident 4 and checked his pulse, but she did not feel any, and she then called for Employee 10 (Licensed Practical Nurse) to call Code Blue and Employee 11 (Registered Nurse). Employee 9 further indicated that while Employee 10 was retrieving the crash cart, another employee called 911 and Employee 12 (Nurse Aide) attempted to remove food from Resident 4's mouth. Employee 9 indicated that she then began performing abdominal thrusts until Employee 11 arrived and started performing CPR. Review of facility provided witness statements for Resident 4's choking incident revealed a statement from Employee 10 (Licensed Practical Nurse) dated June 4, 2026, which indicated that she had just finished delivering medications to a resident and had returned to her medication cart when Employee 9 (Nurse Aide) yelled for her to come to the sub dining room. Employee 10 indicated that Resident 4 was lying flat on his back and was unresponsive and that she called out for Employee 11 (Registered Nurse) and instructed someone to call Employee 8 (Registered Nurse Supervisor). She indicated that Employee 11 started CPR while Employee 10 checked Resident 4's code status, retrieved the AED and applied pads. Employee 10's indicated that other nursing staff arrived from north hall and assisted with chest compressions and ventilation with bag-valve mask until EMS arrived. Review of facility provided witness statements for Resident 4's choking incident revealed a statement from Employee 11 (Registered Nurse), undated, which indicated that at approximately 5:15 PM, a nurse aide alerted a nurse on to an emergency in the dining room and that nurse responded immediately finding Resident 4 on the floor. Employee 11's statement further indicated that Resident 4 was unresponsive, without a pulse and not breathing and that CPR was initiated immediately and continued until EMS personnel arrived and assumed care. During a staff interview with the Director of Nursing (DON) on June 11, 2026, at 2:18 PM, she indicated that ad no documentation that Employee 9 or Employee 12 were (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	trained in performing abdominal thrusts, mouth sweeps, or CPR. During a staff interview with the Nursing Home Administrator (NHA) on June 11, 2026, at 2:22 PM, she confirmed that Resident 4 was left unsupervised while eating and choked. During a staff interview with Employee 8 on June 11, 2026, at 2:45 PM, he indicated that Resident 4 had received the correct meal, which was a regular diet with thin liquids. Employee 8 confirmed that Resident 4 was eating in the dining room unsupervised when the choking incident occurred. Employee 8 indicated that he assisted in providing resuscitation efforts until EMS arrived. Review of information reported by the DON on June 10, 2026, revealed that the coroner's preliminary report of cause of death is accidental death due to choking. The coroner stated that it may take 4-6 weeks until the final autopsy report is available. Review of facility provided plan to correct the identified issue revealed the following:1) Quality Assurance Performance Improvement committee was held on June 5, 2026, to review event and develop correction plan.2) Nursing staff to complete competency for Heimlich Maneuver/Obstructive Airway initiated June 6, 2026.3) Nursing staff re-education on signs and symptoms of choking initiated on June 6, 2026.4) DON/designee to conduct initial audit of nursing staff to confirm active CPR certification, which was completed on June 8, 2026, with no concerns identified.5) DON/designee will conduct audit of CPR certification of five random nursing staff weekly for four weeks and then monthly for two months to ensure active CPR certification.6) Nursing staff statements were obtained from all shifts regarding any observations or concerns with swallowing, coughing, or difficulty eating for Resident 4, which was documented as on-going and no statements were provided.7) DON/designee to conduct initial audit of all residents who require supervision with meals per Speech Therapy to confirm staff are providing supervision and care plan matches which was completed June 8, 2026, with no concerns identified.8) DON/designee will conduct an audit of all dining rooms to ensure staff supervision during meals weekly for four weeks then monthly for two months. 9) Nurse Practice Educator to re-educate nurse aides regarding scope of practice regarding CPR versus Obstructive Airway Management guidelines.10) Ongoing audit results will be monitored through the Quality Assurance Performance Improvement committee for further review and recommendations.11) Compliance date June 8, 2026. Random interviews with five nurses and three nurse aides on June 11, 2026, revealed they were provided with written and verbal education and signed the Employee Training Sign-In Sheets. Observation of lunch meal on June 11, 2026, between 12:25 PM and 1:20 PM, revealed at least one nursing staff member was always present during meal in the South Sub-dining room. During a final staff interview with the NHA and DON on June 11, 2026, at 2:50 PM, the NHA again acknowledged that Resident 4 was eating in the dining room unsupervised when the choking incident occurred. The facility failed to provide adequate supervision for Resident 4 while he was eating, which resulted in him experiencing actual harm of a choking incident resulting in death. 201.4(a) Responsibility of licensee.201.18(b)(1)(3) Management.211.10(d) Resident care policies.211.12(d)(1)(2)(3)(5) Nursing services.		