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	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gettysburg Center	867 York Road Gettysburg, PA 17325

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure protection of residents' personal property while in the facility and upon discharge or after death for two of two discharged residents reviewed (Residents 95 and 96). Findings include: Review of facility policy, Center Operations Policies and Procedure, Personal Property: Patient's, revision date August 15, 2023, read, in part, personnel will identify and record the resident's belongings upon admission to a center. All items brought into the Center will be listed on the Inventory Of Personal Effects form and kept in the resident's clinical chart. Any additional items brought into the Center after admission must be added to this list. The resident representative will sign the Inventory Of Personal Effects for again at discharge to acknowledge receipt of personal property. In the event of the resident's discharge or death, return of any personal property remaining in the Center must be made within 30 days after the discharge or death. Review of Resident 95's clinical record revealed diagnoses that included dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), and chronic kidney disease (CKD - kidneys don't function as they should). Review of Resident 95's clinical record revealed the resident was admitted to the facility January 11, 2023, and was in the process of being transferred to the hospital on January 2, 2024, due to a change in condition and, subsequently passed away. Further clinical record review revealed Resident 95's clinical record failed to contain an inventory of personal effects, or communication with the resident's representative regarding return of personal property remaining at the facility within 30 days after their death. Review of Resident 96's clinical record revealed diagnoses that included dementia and history of falls. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 96's clinical record revealed she was admitted to the facility on [DATE], and left against medical advice on December 25, 2023. Additional review of Resident 96's clinical record revealed that it failed to contain an inventory of personal effects, or communication with the resident representative regarding return of personal property remaining at the facility within 30 days after discharge. During an interview with the Nursing Home Administrator (NHA) on March 21, 2024, at 9:17 AM, it was revealed that the facility could not locate Resident 95's and 96's Inventory Of Personal Effects form. It was further explained that the nursing department initiates the Inventory Of Personal Effects form. It is located in the hard medical record, and could be updated by any staff member. During an interview with the NHA on March 21, 2024, at 10:37 AM, it was revealed that Residents 95 and 96 should have had an inventory of personal effects initiated during admission and signed upon discharge. 28 Pa. code 201.18(b)(2) Management.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative of a resident's transfer in writing to include the reason for the transfer or discharge, date of transfer, location of transfer, statement of the resident's appeal rights, and name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman; and failed to notify a representative of the Office of the State Long-Term Care Ombudsman for three of three resident records reviewed for hospitalization (Residents 21, 84, and 297). Findings include: Review of Resident 21's clinical record on March 20, 2024, at 9:13 AM, revealed diagnoses that included type two diabetes mellitus (the body does not make enough insulin or cannot use it as well as it should) and atrial fibrillation (quivering or irregular heartbeat in the upper chamber of the heart). Further review of Resident 21's clinical record revealed that on October 1 and 5, 2023; November 5, 2023; and January 14, 2024, Resident 21 was transferred out of the facility to the hospital and subsequently was admitted to the hospital. During an interview on March 20, 2024, at 1:05 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the surveyor requested a copy of the Resident Representative transfer notices and Ombudsman notifications for the aforementioned hospital transfers. During an additional interview on March 21, 2024, at 11:43 AM, with the NHA, it was revealed that the facility had not been notifying the Ombudsman due to not having an Admissions Director. The NHA also revealed that the facility had not been aware that transfer notices needed to be sent, and they had not been done. Review of Resident 84's clinical record on March 19, 2024, at 10:20 AM, revealed diagnoses that included dementia (progressive, irreversible degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and Parkinson's disease (disorder of the brain that causes unintentional and uncontrollable movements of the body, stiffness, and difficulty with balance and coordination). Further review of Resident 84's clinical record revealed that on December 8, 2023, Resident 84 was transferred and admitted to the hospital. Resident 84 subsequently returned to the facility on [DATE]. As of March 21, 2024, at 12:15 PM, the facility was unable to provide a hospital transfer form nor evidence that the State Ombudsmans office was notified of Resident 84's transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on March 21, 2024, at 11:43 AM, with the NHA, it was revealed that the facility had not been notifying the Ombudsman due to not having an Admissions Director. The NHA also revealed that the facility had not been aware transfer notices needed to be sent, and they had not been done. Review of Resident 297's clinical record on March 20, 2024, at 9:19 AM, revealed diagnoses that included protein-calorie malnutrition (not enough protein and calories are consumed to meet the body's needs) and dementia. Further review of Resident 297's clinical record revealed that on February 24, 2024, and on March 18, 2024, Resident 297 was transferred out of the facility to the hospital and subsequently was admitted to the hospital. During an interview on March 20, 2024, at 1:05 PM, with the NHA and DON, the surveyor requested a copy of the Resident Representative transfer notices and Ombudsman notifications for the aforementioned hospital transfers. During an additional interview on March 21, 2024, at 11:43 AM, with the NHA, it was revealed that the facility had not been notifying the Ombudsman due to not having an Admissions Director. The NHA also revealed that the facility had not been aware transfer notices needed to be sent, and they had not been done. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.

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F 0657 Level of Harm - Minimal harm or potential for 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. 40010 Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for one of 23 residents reviewed (Resident 88). Findings include: Review of Resident 88's clinical record revealed diagnoses that included muscle weakness (weakness of muscle movements) and hemiplegia (a total or nearly complete paralysis on one side of the body). Observation of Resident 88 on March 18, 2024, at 12:14 PM, revealed Resident 88 in her bed in her room, with a bed-side commode sitting in the corner of the room. An interview with Resident 88 at that time revealed that the bed-side commode belonged to her. Review of Resident 88's care plan on March 18, 2024, revealed an active care plan for, Resident requires assistance for ADL (activities of daily living) care related to: recent hospitalization , cardiovascular accident, with a date initiated of February 8, 2024. Review of the care plan failed to reveal any directions for Resident 88's use of a bed-side commode. An interview with the Director of Nursing on March 20, 2024, at 12:20 PM, revealed that Resident 88's care plan should have been updated to include her use of the bed-side commode, and that it would be updated. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 33879 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to provide and document post-dialysis assessments for one of one resident reviewed for dialysis (Resident 150). Findings include: Review of facility policy, titled NSG253 Dialysis: Hemodialysis (HD) - Communication and Documentation), last revised June 15, 2022, revealed the policy stated, [The facility] staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis (HD) treatments received at a certified dialysis facility. Review of the Practice Standards section of the policy revealed it included, 1. Prior to a patient leaving the [Facility] for HD, a licensed nurse will complete the top portion of the Hemodialysis Communication Record or the state required form and send with the patient to his/her HD facility visit . 3. Upon return of the patient to the [Facility], a licensed nurse will: 3.1 Review the certified dialysis facility communications; 3.2 Evaluate/observe the patient; and 3.3 Complete the post-hemodialysis treatment section on the Hemodialysis Communication Record or state required form. Review of the facility's Hemodialysis Communication Record form, revealed the section for post-hemodialysis stated facility staff were to document the condition of the access site; a resident's blood pressure, temperature and pulse; presence of bruit or thrill (sound that blood makes when flowing through a shunt); post-hemodialysis complications such as dizziness, nausea, vomiting, fatigue or hypotension (low blood pressure); and any new orders from the dialysis center. Finally, the form had an area for the licensed nurse to sign and date the post-dialysis assessment. Review of Resident 150's clinical record on March 18, 2024, at approximately 11:30 AM, revealed diagnoses that included heart failure (decreased ability of the heart to effectively pump blood to the body) with stage 5 chronic kidney disease (severe decrease ability of the kidneys to filter toxins from the blood), which required hemodialysis (a process which removes toxins from the blood using a machine). Review of Resident 150's physician orders revealed Resident 150 was sent to a dialysis center every Monday, Wednesday, and Friday for dialysis treatments. Review of Resident 150's Hemodialysis Communication Record sheets dated March 8 and 18, 2024, revealed that facility staff did not complete the post-hemodialysis treatment section upon Resident 150's return to the facility. Review of both forms revealed that they had been reviewed and signed by a facility medical practioner. During a staff interview on March 21, 2024, at approximately 10:45 AM, Nursing Home Administrator revealed it was the facility's expectation that staff complete the post-dialysis assessment when a resident returns to the facility from a dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33879 Based on observation, staff interviews, and facility policy review, it was determined that the facility failed to ensure medications were stored in a manner that met professional standards for one of three medication carts observed (North 1 Medication cart). Findings include: Review of facility policy, titled 5.3 Storage and Expiration Dating of Medications, Biologicals, last revised August 7, 2023, revealed subsection 9 of Procedures, stated, Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received. Facility should ensure that no transfers between containers are performed by non-Pharmacy personnel. Observation of the North 1 Medication cart on March 19, 2024, at approximately 9:30 AM, revealed that there was a medicine cup filled with small, round, red tablets stowed in the top drawer of the medicine cart. Observation of the medicine cup revealed Senna S (over-the-counter medication used to treat constipation) was written on the medicine cup with marker. The medicine cup was stored with multiple manufacturer-provided over-the-counter medicine containers. During a staff interview at the time of the observations, Employee 1 (Licensed Practical Nurse) stated it was her opinion that staff had placed the medicine in the medicine cup with the other small over-the-counter medicine containers because the pharmacy sent a large bottle of the Senna-S medication. At the time of the interview, Employee 1 displayed the large bottle of Senna-S in a lower drawer. During a staff interview on March 21, 2024, at approximately 10:45 AM, the Nursing Home Administrator confirmed that medications should be stored in the original containers received from pharmacy. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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. 33879 Based on clinical record review, observation, facility policy review, and staff interviews, it was determined that the facility failed to provide medications in a manner consistent with infection control practices for one of four residents observed for medication administration (Resident 3). Findings include: Review of facility policy, titled 6.0 General Dose Preparation and Medication Administration, last revised January 1, 2022, revealed the Applicability, section stated, This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications. Review of Resident 3's clinical record on March 19, 2024, at approximately 10:00 AM, revealed diagnoses that included breast cancer and congestive heart failure (CHF - condition that results in decreased ability of the heart to pump blood efficiently throughout the body). During medication administration observations conducted on March 19, 2024, at approximately 9:05 AM, Employee 1 (Licensed Practical Nurse) was observed preparing medications for administration to Resident 3. During the preparation of the medication, Employee 1 was observed dispensing nine separate medications from multi-dose containers into her bare hand, then dropping the medication into a medicine cup. Employee 1 was also observed dispensing one medication from a blister-pack (card of medications that have individual pills/doses in small separate pockets) into her bare hand, then dropping the medication into the medicine cup. At approximately 9:20 AM, Employee 1 administered the medications to Resident 3. During a staff interview on March 20, 2024, at approximately 1:25 PM, the Director of Nursing revealed it was her expectation that staff only handle medications with gloved hands. 28 Pa. Code 211.12(d)(1)(5) Nursing services.