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	02/20/2025

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 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. 33305 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a transfer notice to the resident or their representative upon transfer out of the facility, which included the following information: 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 for three of three residents reviewed for hospitalization s (Residents 63, 77, and 84). Findings include: Review of the clinical record for Resident 63 on February 19, 2025, revealed clinical diagnoses that included depression disorder (major loss of interest in pleasurable activities, characterized by change in sleep patterns, appetite and or daily routine) and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability). Further review of Resident 63's clinical record revealed transfers to the hospital on March 28, 2024, to April 1, 2024; July 30, 2024, to August 9, 2024; and January 6, 2025, to January 21, 2025. The surveyor requested copies of the transfer, bed hold, and Ombudsman notification. The Ombudsman notification and bed hold notices were provided, however, the transfer notices provided failed to include a statement of the Resident's appeal rights and the name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman. During an interview with the Nursing Home Administrator (NHA) on February 20, 2025, at 10:50 AM, the NHA confirmed that the written transfer notice should include information that is required. Review of Resident 77's clinical record revealed diagnoses that included congestive heart failure (decreased ability of heart to pump blood through out the body) and atrial fibrillation (irregular heartbeat). Review of Resident 77's clinical revealed that Resident 77 was transferred to the hospital after an acute medical change in condition on June 23, 2024. Review of Resident 77's clinical record revealed no evidence that a notice of a transfer letter was provided to Resident 77 or Resident 77's Representative. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's clinical revealed that Resident 77 was transferred to the hospital after an acute medical change in condition on January 22, 2025. Review of Resident 77's clinical record revealed no evidence that a notice of a transfer letter was provided to Resident 77 or Resident 77's representative. During a staff interview on February 20, 2025, at approximately 1:00 PM, the NHA confirmed that the facility did not provide Resident 77 or Resident 77's Representative with a notice of transfer letter for the transfers to the hospital on June 23, 2024, and January 22, 2025. Review of Resident 84's clinical record revealed diagnoses that included dementia with agitation (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and history of falling. Further review of Resident 84's clinical record revealed that she was transferred to the hospital on January 13, 2025, following a fall with fracture, and was subsequently admitted . Review of Resident 84's clinical record failed to reveal that written notification was provided to her or her representative regarding her transfer to the hospital, which included the following required contents: reason for transfer, effective date of the transfer, location to which the Resident was transferred, a statement of the Resident's appeal rights, and contact information for the Office of the State Long-Term Care Ombudsman. During an interview with the NHA on February 20, 2025, at 12:52 PM, she confirmed that the aforementioned transfer notice was not provided to Resident 84 or her Representative. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1) Nursing services

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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 staff interview, it was determined that the facility failed to ensure the care plan was reviewed and revised for one of 24 residents reviewed (Resident 4). Findings Include: Review of Resident 4's clinical record revealed diagnoses that included congestive heart failure (a serious condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs) and anxiety (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life). Observation of Resident 4 on February 17, 2025, at 11:22 AM, revealed Resident 4 lying in bed and Resident 4 had facial hair. Review of Resident 4's care plan revealed a focus area of, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting, with a revision date of August 31, 2024. Review of the interventions of this care plan failed to mention any expectation that Resident 4 refuses care or that Resident 4 would complete their own facial shaving. Interview with the Director of Nursing on February 19, 2025, at 11:56 AM, revealed that Resident 4 often refuses care and completes her own facial shaving when she feels it is necessary, and that it should have and would be added to the care plan. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33305 Based on observation, staff interviews, clinical record review, and facility's policy review, it was determined that the facility failed to ensure that a resident with a pressure ulcer received care consistent with professional standards of practice for one of three residents reviewed (Resident 54). Findings include: A review of the facility policy, titled Wound Dressings: Aseptic, last reviewed January 2025, directed staff to do the following: after applying and securing the clean dressing, to apply a label with date and initials. A review of the clinical record for Resident 54 on February 19, 2025, revealed clinical diagnoses that included stage IV sacral pressure ulcer (ulcer involving loss of skin layers, exposing muscle and bone of the large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) and bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 54's physician orders dated February 2025, included an order for wound care to the sacrum every evening shift. The physician order stated, cleanse with normal saline solution (salt solution), lightly pack with calcium alginate (absorbs excess wound exudate, creating a moist environment that promotes wound healing), cover with bordered gauze island dressing. Observation of wound care on February 19, 2025, at 2:23 PM, revealed there was no dressing in place to indicate when the last dressing change was completed. Employee 6 (Registered Nurse) had no explanation for the missing dressing and agreed that there should have been a dressing in place from the previous day. During an interview with the Nursing Home Administrator (NHA) on February 20, 2025, at 10:50 AM, the NHA agreed that Resident 54's dressing should have been in place from the previous treatment and dated and initialed as the facility policy stated. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37116 Based on observation, facility policy review, and staff interview, it was determined that the facility failed to ensure protection from contamination of a urinary catheter for one of three residents reviewed with indwelling catheters (Resident 17). Findings include: Review of facility policy, Catheter:Indwelling Urinary - Care of, revised February 1, 2023, revealed, Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off of the floor. Review of Resident 17's clinical record revealed diagnoses that included obstructive uropathy (condition in which urine cannot drain through the urinary tract and causes kidney damage) and hydronephrosis (swelling of the kidneys when urine flow is obstructed in any part of the urinary tract). Review of Resident 17's care plan revealed that he utilized an indwelling foley catheter (small, flexible tube that can be inserted through the urethra and into the bladder, allowing urine to drain) for obstructive uropathy. Further review of Resident 17's care plan revealed Keep catheter off floor. Observation of Resident 17 on February 18, 2025, at 11:43 AM, revealed him being transported by staff in his wheelchair, and his catheter tubing was dragging on the ground underneath his chair. During an interview with the Nursing Home Administrator on February 20, 2025, at 10:45 AM, she revealed the expectation that Resident 17's catheter tubing should not have been touching the ground. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49123 Based on observations and staff interview, it was determined that the facility failed to post required nurse staffing information on a daily basis. Findings Include: Observations on February 19, 2025, at 9:02 AM, and February 20, 2025, at 9:20 AM, revealed the posted facility's nursing staff information was dated for February 18, 2025. During an interview with the Nursing Home Administrator on February 20, 2025, at approximately 10:30 AM, it was revealed that it was the facility's expectation that posted staffing be updated daily. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and staff interviews, it was determined that the facility failed to ensure medications were stored in a manner that met professional standards for three of three medication carts observed (North Hall B, North Hall C, and South Hall A medication carts). Findings include: Observations of North B Hall medication cart on February 19, 2025 revealed multiple loose pills (whole and fragmented) and multi-colored granular dust (consistent with crushed/degraded pills) located in the medication cart drawers and in the bottom of the cart under the drawers. It was also observed that a blister-pack of medications was lodged behind the lowest drawer, which had been filled by the pharmacy in April 2024, for a Resident that had been discharged from the facility in April 2024. During a staff interview directly after the aforementioned observation, Employee 3 (Licensed Practical Nurse) revealed that she was unaware of the facility's procedure for cleaning the medication carts. Observations of North C Hall medication cart on February 19, 2025, revealed multiple loose pills (whole and fragmented) and multi-colored granular dust (consistent with crushed/degraded pills) located in the medication cart drawers and in the bottom of the cart under the drawers. Observations of the South A Hall medication cart on February 19, 2025, revealed multiple loose pills (whole and fragmented) and multi-colored granular dust (consistent with crushed/degraded pills) located in the medication cart drawers and in the bottom of the cart under the drawers. During a staff interview on February 19, 2025, directly after the aforementioned observation of South A Hall medication cart, Employee 4 (Licensed Practical Nurse) revealed she was familiar with the facility's procedure regarding cleaning of the medication carts as she was recently hired by the facility. During a staff interview on February 20, 2025, at approximately 1:00 PM, Nursing Home Administrator (NHA) revealed that the facility did not have policy or procedure in place that addressed how often medication carts should be inspected and cleaned. During the interview, the NHA revealed that it was the facility's expectation that medication carts are clean 211.12(d)(1)(3)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37116 Based on observations, facility document review, and staff interviews, it was determined that the facility failed to serve all items on the posted menu, and failed to serve items in the appropriate quantity for one of 12 residents observed (Resident 8). Findings include: Review of Resident 8's clinical record revealed diagnoses that included dysphagia (difficulty swallowing) and need for assistance with personal care. Review of Resident 8's physician orders revealed an order for a regular/liberalized diet, dysphagia puree texture (type of diet for those with swallowing difficulties consisting of pureed, homogenous and cohesive foods that are pudding-like), effective September 26, 2024. Review of Resident 8's lunch meal ticket for February 18, 2025, (paper slip provided with tray that indicates diet, items to be received, as well as resident allergies and preferences) revealed she was to receive the following: #8 scoop (1/2 cup/4 oz) pureed dysphagia sweet and sour meatballs, pureed boiled potatoes, pureed white rice, pureed warm bread, pudding, and brown gravy. Observation of meal service on February 18, 2025, at 12:39 PM, revealed Employee 1 (Dietary Aide) plating Resident 8's meal, then nursing staff delivering the meal tray. Employee 1 served the pureed meatballs using a #16 scoop (1/4 cup/2 oz). Additionally, it was observed that Resident 8 did not receive pureed rice. During an interview with Employee 1 on February 18, 2025, at 12:47 PM, he confirmed that he missed serving Resident 8's rice. He also confirmed that he used a #16 scoop to serve the pureed meatballs. Review of Resident 8's lunch meal ticket for February 19, 2025, revealed that she was supposed to receive 2 ounces of brown gravy with her meal. Observation on February 19, 2025, at 12:50 PM, revealed Resident 8 was served her lunch meal in her room. No gravy was present on her tray. During an immediate interview with Employee 2 (Dietary Aide), she confirmed that she had not given Resident 8 her gravy. During an interview with the Nursing Home Administrator on February 20, 2025, at 12:34 PM, she revealed the expectation that Resident 8 should have received all of her food and in the correct portion sizes. 28 Pa. Code 201.14(a) Responsibility of licensee