

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Transitions Healthcare Gettysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 595 Biglerville 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on observation, review of clinical record, facility documentation review, facility policy review, hospital records review, and staff and resident interviews, it was determined that the facility failed to ensure that residents were protected from neglect during provision of care for one of four residents reviewed (Resident 1). The facility staff member failed to verify the resident and transfer status, which resulted in actual harm to Resident 1 who sustained a laceration to the right lower leg, transfer to the hospital, and received 13 sutures to the right lower leg.</p> <p>Findings Include:</p> <p>Review of the facility's policy, titled Abuse Prohibition-Abuse, Neglect, and Misappropriation of Resident's Property, revised June 14, 2023, revealed that neglect is defined at 483.5 as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.</p> <p>Review of Resident 1's clinical record revealed that the Resident was admitted to the facility on [DATE], with diagnoses that included anorexia nervosa (an eating disorder causing people to obsess about weight and what they eat) and failure to thrive (doesn't gain weight normally).</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS - a periodic review of a resident's assessment and care needs), dated May 2, 2024, revealed that Resident 1 needed two persons' physical assistance with staff for transfer to move between surfaces including to and from bed, chair, and wheelchair.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's current care plan revealed that Resident 1 had an activity of daily living self-care performance deficit related to weakness. The care plan was revised on June 6, 2024, to reflect Resident 1 transfers via a full mechanical lift. During an interview with the Director of Nursing (DON), she stated that Resident 1 was a 2-person transfer with a rolling walker prior to the revision on June 6, 2024.</p> <p>Review of Resident 1's physician orders revealed that on October 25, 2023, the physician order was to transfer with assistance of 2-persons and a rolling walker. On June 6, 2024, the physician orders were revised to transfer via mechanical lift. Concluding that, at the time of the incident, the Resident was to be transferred with 2-persons assisting and her rolling walker.</p> <p>Review of facility reported incident, submitted on June 6, 2024, revealed that when Resident 1 was being transferred from bed to wheelchair by Employee 1 (Nursing Assistant) she noticed a laceration to the right lower leg when pulling Resident 1 back in wheelchair. Per resident's care plan, resident transfers with 2 assist and rolling walker. It is reported that Employee 1 transferred Resident 1 with 1 assist. The facility substantiated neglect and told the staffing agency that Employee 1 is a Do Not Return to facility.</p> <p>Review of Resident 1's nursing notes dated June 4, 2023, at 6:04 AM, stated that she was transferred to the hospital emergency department for right leg shin wound, physician and Resident Representative were made aware.</p> <p>A review of Employee 1's telephone statement obtained by the Nursing Home Administrator on June 5, 2024, revealed Resident 1 sustained a skin tear when re-positioning her in the wheelchair during a transfer. Employee 1 stated, Resident 1 pushed up on the wheelchair via arm rest and I pulled, hitting her leg on the piece of her wheelchair where the leg rest go. I reported the incident to the Registered Nurse immediately. Employee 1 stated that she was given instruction to weigh a resident, but went into the wrong room and proceeded to transfer Resident 1 out of bed independently to obtain a weight. Resident 1 was not supposed to be weighed that shift and had no orders to be out of bed to be weighed.</p> <p>A review of Employee 1's personnel file on June 10, 2024, revealed her most recent completion of training on abuse, neglect, and misappropriation was on July 7, 2023.</p> <p>During an interview with Resident 1 on June 10, 2024, at approximately 10:15 AM, she was asked if she could recall what happened when she injured her leg she replied, yes. Resident 1 added, I asked the nurse why she was getting me out of bed to be weighed and she told me, that's how we weigh people. Resident 1 also confirmed there was only one staff person who assisted her out of bed. Resident 1 stated, when she pulled me back in the wheelchair my leg was caught by the metal piece on the wheelchair.</p> <p>A written statement by Employee 2 (LPN-Licensed Practical Nurse) on June 4, 2024, revealed that she overheard the LPN charge nurse inform Employee 1 that the transfer status for all residents is on the back of their closet door. She also stated that Resident 1 told Employee 2 and the EMT that she sustained the skin tear during the transfer to her wheelchair from her bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the written statement by Employee 3 (Nurse Aide) on June 4, 2024, stated that Employee 1 was told to wash and dress Resident 1 only and NOT to get her out of bed. The statement also said that Employee 3 reviewed with Employee 1 the residents who needed washed up and dressed and not to get out of bed; and also the residents who needed weighed. During a phone interview with Employee 3 on June 10, 2024, at 10:30 AM, it was confirmed that Employee 1 was told by Employee 3 to wash and dress Resident 1 only, and not to get her out of bed.</p> <p>A review of hospital records for Resident 1 dated June 4, 2024, stated, Resident 1 sustained an L-shaped laceration to the lateral aspect of the right lower extremity, there is a flap of skin evident, adipose tissue exposed, no muscle belly exposure (fleshy part of the skeletal muscle); L-shape approximately 7 cm x 6 cm (total laceration 13 cm). Resident 1 received 13 sutures to repair the laceration. A non-adherent (non-stick) dressing and antibiotic ointment was applied.</p> <p>An interview with the DON on June 10, 2024, at 11:00 AM, confirmed that the facility failed to follow the transfer status and provide 2-person assistance during the transfer for Resident 1.</p> <p>The facility failed to ensure a Resident was protected from neglect during the provision of care by transferring the Resident from the bed to the wheelchair with the assistance of only one staff. Employee 1 neglected to follow the transfer status and failed to confirm the resident care needs. This failure resulted in actual harm to Resident 1 who sustained a laceration, transfer to the hospital, and required 13 sutures.</p> <p>28 Pa Code 211.10(d) Patient care policies</p> <p>28 Pa Code 211.12 (c) Nursing Services</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on review of clinical records, facility policy review, review of facility investigation reports, hospital record review, and resident and staff interviews, it was determined that the facility failed to provide the assistance required for a safe transfer for one of four residents reviewed (Resident 1), resulting in actual harm as evidenced by a laceration that required transfer to the hospital and 13 sutures.</p> <p>Findings Include:</p> <p>A review of the facility policy, titled Transfer/Lift Policy, stated, all resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan.</p> <p>Review of Resident 1's clinical record revealed that the Resident was admitted to the facility on [DATE], with diagnoses that included anorexia nervosa (an eating disorder causing people to obsess about weight and what they eat) and failure to thrive (doesn't gain weight normally).</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS-a periodic review of a resident's assessment and care needs), dated May 2, 2024, revealed that Resident 1 needed 2-persons' physical assistance with staff for transfer to move between surfaces including to and from bed, chair, wheelchair, and some aspects of toilet use.</p> <p>A review of Resident 1's current care plan revealed that Resident 1 had an activity of daily living self-care performance deficit related to weakness. The care plan was revised on June 6, 2024, to reflect Resident 1 transfers via a full mechanical lift. During an interview with the Director of Nursing (DON), she stated that Resident 1 was a 2-person transfer with a rolling walker prior to the revision on June 6, 2024.</p> <p>A review of Resident 1's physician order summary on June 10, 2024, revealed that on October 25, 2023, the physician order was to transfer with assistance of 2-person assist and a rolling walker. On June 6, 2024, the physician orders were revised to transfer via mechanical lift.</p> <p>A review of the incident report for June 4, 2024, revealed Resident 1 sustained a laceration to the right shin area and it was cleaned with normal saline (salt) solution, bandage applied, and physician notified. An order was obtained to send the Resident to the hospital emergency department for evaluation and treatment. The Resident was transferred by ambulance on June 6, 2024, at 6:25 AM. The laceration was repaired with 13 sutures. Resident 1 returned to the facility on [DATE], at 8:14 AM.</p> <p>A review of hospital records for Resident 1 dated June 4, 2024, stated that Resident 1 sustained an L-shaped laceration to the lateral aspect of the right lower extremity, there is a flap of skin evident, adipose tissue exposed, no muscle belly exposure (fleshy part of the skeletal muscle); L-shape approximately 7 cm x 6 cm (total laceration 13 cm). Resident 1 received 13 sutures to repair the laceration. A non-adherent (non-stick) dressing and antibiotic ointment was applied.</p> <p>(continued on next page)</p>		

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