STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395798	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Gettysburg	595 Biglerville 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure a resident's right to file a grievance anonymously was honored on three of three resident living areas.Findings include: Review of facility, titled OPS-352 Grievance Policy, with a last review date of August 27, 2025, revealed, in part, 1. A concern/grievance may be made in person, in writing, by telephone or by mail and may be reported anonymously. The facility may not require the signature of the resident, the resident's representative or concerned party on a concern/grievance. 2. Grievance forms are located at each nursing station, the receptionists' office and outside the Social Service office. Forms may be returned to the receptionists' office, the Social Service department and/or to facility staff and management. During a Resident group meeting with Residents 30, 51, 55, 66, and 76 on September 23, 2025, at 10:30 AM, Residents 30, 51, 66, and 76, all indicated that they did not know how to file a grievance or how to do it anonymously. Resident 51 indicated that she just tells the facility Social Worker if she has an issue. Residents 30, 66, and 76 concurred that they just tell the Social Worker, their nurses, or others in management if they have concern. Resident 55 offered no comments in the discussion. Observation of grievance process information posted on a bulletin board on all three living areas of the facility on September 23, 2025, between 1:00 PM and 1:30 PM, revealed a posting that indicated If you have a concern or a grievance to file, you may complete a grievance form. Please return this form to the RN Supervisor or Nurse Manager. You may also contact: Nursing Home Administrator [name, email, and phone number provided] or Grievance Coordinator/Director of Social Services [name, email, and phone number provided]. There was no drop box or any location noted in which a resident could file/place an anonymous grievance. During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing on September 25, 2025, at 11:12 AM, the NHA confirmed that there should have been a process in place for residents to be able to submit grievances anonymously. She also confirmed that the facility revised their process on September 24, 2025, after the concern was brought to their attention by the surveyor. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18 (b)(1)(2) Management.28 Pa. Code 201.29 (a) Resident rights.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to ensure the resident assessment accurately reflected the resident's status for four of 24 residents reviewed (Residents 5, 75, 99, and 118).Findings include:Review of the facility policy, titled OPS Minimum Data Set Submission/Accuracy, with a last review date of August 27, 2025, stated, Each Minimum Data Set Submission (MDS) [an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs] will be completed accurately and timely and in accordance with RAI (Resident Assessment Instrument) guidelines and requirements.Review of Resident 5's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, muscle weakness, and moderate protein-calorie malnutrition (the state of inadequate food intake which leads to changes in body composition and function). Review of Resident 5's quarterly MDS dated [DATE], revealed in Section M. Skin Conditions at question M0100A that she was coded as not having a pressure ulcer. Further review of this section revealed at question M0210 that she was coded as having one or more unhealed pressure ulcers/injuries; and at question M0300C1 she was coded as having one Stage 3 pressure ulcer (a full-thickness tissue loss wound where the tissue just under the skin may be visible, but no bone, tendon, or muscle is exposed). During a staff interview with the Director of Nursing (DON) on September 24, 2025, at 2:00 PM, she confirmed Resident 5's MDS was coded inaccurately at question M0100A and that a correction would be submitted. She further indicated that she would expect a resident's MDS to be an accurate reflection of the Resident. Review of Resident 75's clinical record revealed diagnoses that included nicotine dependence (cigarettes daily) and hypertension (high/elevated blood pressure). Review of Resident 75's care plan revealed the Resident is evaluated regularly for smoking safely. The care plan for smoking was initiated June 7, 2018.A review of Resident 75's Annual MDS dated [DATE], Section J1300, Current Tobacco Use was marked no and should have been marked yes. Section I - Active Diagnoses, Subtitled Other failed to show that Resident 118 is nicotine dependent.During an interview with Resident 75 on September 22, 2025, the Resident stated that he is permitted to smoke daily in the courtyard at 10:00 AM, 1:30 PM, 4:00 PM, and 7:00 PM. The Resident also said that he is supervised by staff and wears a safety apron.A review of Resident 75's Annual MDS dated [DATE], revealed a BIMS (brief interview of mental status) score of 14, indicating cognition intact.During an interview with the DON on September 25, 2025, at 11:00 AM, she confirmed the error with Section J1300 and said a modification had been completed for that MDS.Review of Resident 99's clinical record revealed diagnoses that included expressive aphasia (partial loss of the ability to produce language), atherosclerotic heart disease (a disease in which plaque builds up inside your arteries. Arteries are blood vessels that carry oxygen-rich blood to your heart and other parts of your body. Plaque is made up of fat, cholesterol, calcium, and other substances found in the blood), and cerebral infarction (stroke).Review of Resident 99's Quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating cognition was intact. Further review of Section B. - Hearing, Speech, and Vision, Subsection B0600. Speech Clarity was coded a 0, indicating speech was clear.During the screening process on September 22, 2025, the surveyor introduced themself to Resident 99 and attempted to have a conversation asking the Resident if there were any concerns with the care or services being provided. The Resident gave eye contact and tried to speak but a response could not be understood, and then the Resident just nodded her head indicating a response of no concerns.Review of Resident 99's care plan revealed a focus with communication related to diagnosis of Expressive Aphasia, initiated March 14, 2024.Observation of Employee 5 (Registered Nurse) on September 5, 2025, who attempted to interview Resident 99, revealed Employee 5 had to clarify any response provided by Resident 99. Resident 99 appeared to struggle to speak and picked up a whiteboard and began to write all her responses to Employee 5. Resident 99's whiteboard appeared to be used frequently based on previous responses observed on the whiteboard, and having to erase previous responses to continue interaction with Employee 5.Review of Resident 99's progress notes, sub-titled Plan of Care dated December 27, 2024; March 10, 2025; June 15, 2025; and July 30, 2025, all stated speech is slurred.During an interview with the DON on September 25, 2025, at 11:00 AM, the DON confirmed that Section B. - Hearing, Speech, and Vision, Subsection B0600, Speech Clarity should be coded a 1, indicating

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, observation, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for two of 24 residents reviewed (Residents 5 and 116).Findings include: Facility policy, titled Care Plan - Comprehensive, last reviewed August 27, 2025, read, in part, Each resident will have a comprehensive care plan developed that is individualized, includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident, and reflect the resident's cultural references, values, and practices. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident. Review of Resident 5's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep), hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, and legal blindness. Observation of Resident 5 on September 22, 2025, at 1:21 PM, revealed a CPAP (continuous positive airway pressure - a machine that uses mild air pressure to keep breathing airways open while one sleeps; used to treat sleep apnea) machine on her bedside stand. Review of Resident 5's current physician orders revealed an order for CPAP on at bedtime and remove in the morning, dated February 2, 2025. Review of Resident 5's annual comprehensive MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident, such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of July 4, 2025, revealed in Section O. Special Treatments, Procedures, and Programs that Resident 5 utilized a non-invasive ventilator during the assessment reference period. Review of Resident 5's quarterly MDS with the assessment reference date of August 29, 2025, revealed in Section O. Special Treatments, Procedures, and Programs that Resident 5 continued to utilize a non-invasive ventilator (CPAP) during the assessment reference period. Review of Resident 5's care plan failed to reveal a respiratory care plan or any documentation of Resident 5's use of a CPAP. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on September 25, 2025, at 11:17 AM, the DON indicated that she would expect Resident 5's CPAP use to be on her care plan. Review of Resident 116's clinical record revealed diagnoses that included dementia with behavioral disturbance (cognitive decline accompanied by significant changes in behavior) and delusional disorders (serious mental illness where a person cannot tell what is real from what is imaginary). Review of Resident 116's physician orders revealed orders for Seroquel (an antipsychotic medication) 100 mg twice daily and Seroquel 25 mg twice daily for dementia with delusional disorder. Review of Resident 116's annual comprehensive MDS with an assessment reference date of November 27, 2024, revealed Resident 116 was coded as receiving antipsychotic medication. In addition, the care area assessment summary worksheet completed in conjunction with this MDS indicated Resident 116 had triggered for antipsychotic medication use and that it would be care planned. Review of Resident 116's quarterly MDS with an assessment reference date of September 4, 2025, revealed Resident 116 was coded as receiving antipsychotic medication. Review of Resident 116's comprehensive care plan failed to reveal any care planning for antipsychotic medication use. During a staff interview on September 25, 2025, at 10:03 AM, with the NHA and DON, the DON stated it was the expectation of the facility that comprehensive care plans be developed accurately. 28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) 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. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the resident plan of care for one of 24 residents reviewed (Resident 5).Findings include: Review of facility policy, titled Care Plan - Comprehensive, last reviewed August 27, 2025, read, in part, Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition changes. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition; d. At least quarterly. Review of Resident 5's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, muscle weakness, and moderate protein-calorie malnutrition (the state of inadequate food intake which leads to changes in body composition and function). Review of Resident 5's clinical record revealed that she had a Stage 3 pressure ulcer from July 2, 2025, to August 12, 2025. Review of Resident 5's clinical record revealed that she had a quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of August 29, 2025, which indicated that she had no pressure ulcers. Review of Resident 5's care plan revealed an active care plan focus for altered skin integrity related to limited mobility and incontinence open area to coccyx, with an initiated date of July 2, 2025. During a staff interview with the Director of Nursing on September 24, 2025, at 2:00 PM, she confirmed that Resident 5's care plan should have been revised when the pressure ulcer was resolved or at least after her most recent MDS was completed. 28 Pa. Code 211.12(d)(2)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of two residents reviewed (Resident 5).Findings include: Review of facility policy, titled CLIN-157 CPAP/BIPAP, with a last review date of August 27, 2025, revealed, in part, orders must include pressure and hours of use and may include supplemental oxygen and mask size. The policy failed to indicate how the mask was to be stored when not in use. Review of Resident 5's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep), hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, and legal blindness. Review of Resident 5's current physician orders revealed an order for CPAP (continuous positive airway pressure - a machine that uses mild air pressure to keep breathing airways open while one sleeps; used to treat sleep apnea) on at bedtime and remove in the morning, dated February 2, 2025. The order failed to include any ordered settings for the CPAP. Review of Resident 5's care plan failed to reveal a respiratory care plan or any documentation of Resident 5's use of a CPAP. Observation of Resident 5 on September 22, 2025, at 1:21 PM, revealed a CPAP machine on her bedside stand. Her mask was observed hanging on a hook on the wall above the head of her bed. The mask was directly touching the wall. Follow-up observations of Resident 5 on September 23, 2025, at 9:32 AM; September 24, 2025, at 9:51 AM; and September 25, 2025, at 9:05 AM, all revealed the same observation of her CPAP mask hanging on the hook directly touching the wall. During a staff interview with the Nursing Home Administrator and the Director of Nursing (DON) on September 25, 2025, at 11:17 AM, the DON confirmed that Resident 5's CPAP order did not include the machine settings and that she would expect that information to have been included in the order. She confirmed that Resident 5's care plan should have included her respiratory diagnosis and all appropriate care interventions. She said that she has read mixed recommendations on how the masks should be stored when not in use (placed in a protective bag or stored in open air) but confirmed that the facility policy did not include guidance on how masks should be stored when not in use. 28 Pa. Code 211. 12(d)(1)(2)(5) Nursing services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, food committee meeting minutes, grievance review, completion of one meal test tray, and resident and staff interviews, it was determined that the facility failed to provide food and beverages that were at an appetizing temperature.Findings include:Review of Food Committee Meeting Minutes from July 29, 2025, revealed under complaints/concerns veggies are cold.Review of May 2025 Grievance Log revealed Resident 34 filed a grievance on May 6, 2025, that she feels she should be able to have her tea served hotter. Residents 30, 51, 66, and 76 who attended a group meeting on September 23, 2025, at 10:40 AM, revealed food temperatures are sometimes cold and they have to ask staff to reheat their food, and that coffee is often not hot enough. During an interview with Resident 4 on September 23, 2025, at 10:40 AM, he revealed his food isn't always served hot. Observation during meal tray line service on September 23, 2025, at 11:51 AM, revealed staff were placing two mugs with handles on the trays. Interview with Employee 1 (Dietary Manager) on September 23, 2025, at 11:52 AM, revealed she was not sure why they serve mugs for both hot and cold beverages but that has been the facility process since she has been employed there. During an interview with Employee 1 on September 23, 2025, at 12:03 PM, she revealed the expectation that hot foods and hot beverages should be served above 135 degrees F, and cold foods and beverages should be served below 50 degrees F. A test tray was completed on September 23, 2025, at 12:04 PM, utilizing a lunch tray served from the tray line in the main facility kitchen. The test tray was served and placed in a closed food cart approximately two minutes prior to being delivered to the East Hall (other trays for room service were being delivered there also at that time). The test tray included: Open faced roast turkey sandwich, mashed potatoes with gravy, creamed corn, cherry crisp dessert, coffee and iced tea. Test tray temperatures were taken by Employee 1, and revealed:Creamed corn was 115 degrees F (Fahrenheit-unit of measure), not acceptable.Iced tea was served in a hot beverage mug, the mug was only half full with tea without ice, and the temperature was 57 degrees F, not acceptable.Coffee was 115 degrees F, not acceptable.Interview with Employee 1 on September 23, 2025, at 12:07 PM, the surveyor revealed the concern with the test tray temperatures and serving cold beverages in a warm beverage mug. Employee 1 revealed they are working to improve meal service, and she has ordered new carafes for hot beverages, but the one on the cart that had the coffee for the test tray was an old carafe. Interview with the Nursing Home Administrator (NHA) on September 24, 2025, at 2:27 PM, the surveyor revealed the concern with the test tray temperatures and service of cold beverages. The NHA revealed she would expect palatable and appetizing food and beverage temperatures, and the facility will inquire about ordering cold beverage cups. 28 Pa. Code 201.14(a) Responsibility of licensee