

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Transitions Healthcare Shook Home		STREET ADDRESS, CITY, STATE, ZIP CODE  55 South Second Street Chambersburg, PA 17201	

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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, hospital record review, and resident representative and staff interviews, it was determined that the facility failed to notify the physician after a change in a resident's condition and failed to notify a resident's representative of a change in treatment for one of four residents reviewed (Resident 1). Immediate Jeopardy was identified because the failure to notify the physician resulted in a lack of physician oversight. This caused a delay in treatment, which resulted in transfer to the hospital for hypovolemic shock (emergency condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body), hypotension (low blood pressure), hyperglycemia (elevated blood sugar), and cardiac arrest for Resident 1.</p> <p>Findings include:</p> <p>Review of facility policy, titled Change of Condition, with a last revision date of February 22, 2024, revealed the following: It is the policy of the Facility to inform residents, physicians/CRNP's (Certified Registered Nurse Practitioners), and resident representatives of a change in the resident's condition; Licensed nursing staff will: 1. Evaluate any changes noted through direct observation or by assigned staff or any changes noted in report at change of shift or as noted on 24 Hour Report; 2. Obtain a complete set of vital signs (temperature, pulse respirations, and blood pressure) at the onset of the change and/or more often as appropriate or ordered by the physician/CRNP; 5. Notify the physician/CRNP immediately if the condition appears serious; 6. Notify the resident's representative of the change and any changes made to the resident's plan of care; 7. Address the change on the 24 Hour Report or facility specific form at the nursing station for follow through by the next shift; and 9b. Licensed staff will document findings in the EHR (electronic health record) regarding the change of condition and observations.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and hypertension (elevated blood pressure).</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's nursing progress note dated May 22, 2024, at 1:30 PM, revealed that Resident 1 was complaining of not feeling well and stating that she felt full. Blood pressure 85/58 (normal is 120/80), abdomen was large, soft, and non-tender, and the Resident denied nausea and pain. The note further indicated that Resident 1 was given ginger ale soda and added to alert charting and the physician list.</p> <p>On June 17, 2024, at 12:44 PM, the Director of Nursing (DON) stated that alert charting means that the resident's name and symptoms to monitor will be put on a paper in a book at the nurse's station. She stated that nursing staff are then to document their findings in the resident's medical record.</p> <p>On June 17, 2024, at 1:18 PM, the DON stated when a resident is added to the physician list, it means the physician will see them the next time they are in the building. She further stated that the Nurse Practitioner (Employee 1) comes in on Tuesdays and Fridays; so Resident 1 would have been seen on Friday, May 24, 2024. In addition, the DON provided daily assignment sheets for review, which are not part of the clinical record but did reflect Resident 1's low blood pressures.</p> <p>Review of the facility form, titled Daily Assignment Sheet, revealed Resident 1 had the following blood pressures documented on the paper form:</p> <p>May 23, 2024, 6 AM-2 PM shift- 80/60</p> <p>May 23, 2024, 2 PM-10 PM shift- 80/58.</p> <p>Review of Resident 1's clinical record revealed the aforementioned blood pressures were not documented in Resident 1's clinical record and there is no evidence that the provider was made aware of those blood pressures.</p> <p>Review of Resident 1's nursing progress note dated May 22, 2024, at 6:10 PM, revealed that an assessment was completed on Resident 1 after the nurse aide stated she was more difficult to transfer than usual. Assessment completed all unremarkable except resident had hypoactive bowel sounds. Day two of no BM [bowel movement] after having a medium on 5/20. Resident is to MD in AM to assess changes noted today. Neurologically intact. Stated that she does feel less full than this AM and did state that she was going to attempt to eat PM meal. Continue with current POC [plan of care], monitor anticipate needs.</p> <p>Review of Resident 1's clinical record revealed no evidence that Resident 1 was assessed by the physician on May 22 or 23, 2024.</p> <p>Review of Resident 1's physical therapy treatment notes revealed a note dated May 23, 2024, at 12:06 PM, that indicated Resident 1 had been trialed standing in supported position, with evidence of decreased ability to stand upright and to stand pivot. The note further indicated that Resident 1 had poor alertness throughout the session and that they were being downgraded to a stand pivot disc with the assistance of two staff due to safety concerns.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's occupational therapy treatment notes revealed a note dated May 23, 2024, at 10:33 AM, that indicated Resident 1 attempted to engage in sit to stand transfers and stand pivot disc transfers but was very lethargic and fatigued requiring moderate to maximum assistance of two people. The note further indicated that Resident 1 was reporting that they had a headache and did not feel well and that nursing was made aware.</p> <p>Review of Resident 1's nursing progress note dated May 24, 2024, revealed that the RN (Registered Nurse) was called to assess the Resident and noted the following vital signs: Temperature 96.6; pulse 60 and regular; respirations 12; blood pressure 106/52; pulse ox 84% on room air.</p> <p>Further review of Resident 1's progress notes revealed Employee 1 (Nurse Practitioner) reported that resident was confused and lethargic. Upon assessment, resident was gray in color and diaphoretic. Denies pain. Resident slowly to respond. Resident kept closing her eyes. BS [blood sugar] 552 [normal is 70-100]. Resident unable to state what was wrong. A new order was received to send Resident 1 to the emergency department. The Facility called 911 and Resident 1 left the facility via ambulance at 7:40 AM.</p> <p>Review of Resident 1's EMS (Emergency Medical Services) record dated May 24, 2024, revealed that, upon arrival to the facility, the RN told EMS that Resident 1 had been hypotensive (low blood pressure), very pale, clammy, and had an altered mental status for the past two days. The RN stated that Resident 1's blood sugar was 552 on the morning of May 24, 2024, no insulin was given, and that no other glucose readings were documented during Resident 1's admission to the facility. The EMS report further revealed that the RN stated Resident 1's blood pressure was in the 60's over the 40's the past two days. Initial blood pressure from EMS at 7:34 AM was 82/51. It was also noted on assessment that Resident 1 was very cold and very pale as if in a GI [gastrointestinal] bleed.</p> <p>Further review of the EMS report for Resident 1 revealed the following blood pressure readings:</p> <p>7:48 AM 72/43</p> <p>7:52 AM 85/59</p> <p>7:57 AM 86/63</p> <p>8:03 AM 81/58.</p> <p>Review of Resident 1's hospital records dated May 24, 2024, revealed that they arrived at the emergency department at 8:06 AM, and the Resident was being treated for shock, hypotension (low blood pressure), gastrointestinal bleeding, and acute kidney injury. Resident 1 was noted to be profoundly pale, clammy to touch, with a low blood pressure of 84/64. At 9:08 AM, Resident 1 was noted to have no pulse and resuscitation efforts were initiated but were unsuccessful.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee 1 (Nurse Practitioner) on June 18, 2024, from 8:30 AM to 8:37 AM, Employee 1 confirmed that Resident 1 was started on Midodrine (medication to treat low blood pressure) after notification of a low blood pressure. Employee 1 stated that she was only aware of one low blood pressure and then she was told that Resident 1's blood pressure went back up. Employee 1 stated, "if I knew [Resident 1] was running in the 80's on multiple occasions, it may have changed the treatment course. Employee 1 indicated that when she arrived to visit Resident 1 on May 24, 2024, she noted a change in Resident 1's condition and gave the order to send Resident 1 to the hospital.</p> <p>Further review of Resident 1's clinical record failed to reveal any documentation that Resident 1's Representative was made aware of the additional low blood pressures or that a new medication was ordered.</p> <p>During a phone interview with the Nursing Home Administrator (NHA) on June 18, 2024, at approximately 10:00 AM, the NHA stated that they placed Resident 1 on charting and the physician list to be checked. The NHA indicated that he had spoken with Employee 4 (Registered Nurse) and that it was his understanding that when Employee 4 called Employee 1, Resident 1 was placed on alert charting, both low blood pressures were shared, and Employee 1 ordered a medication to treat the low blood pressure. During this conversation, it was shared with the NHA that Employee 1 indicated that they were not informed of the multiple low blood pressures and that there was no documentation in Resident 1's clinical record that Employee 1 was made aware of the blood pressures, that a treatment order was obtained, or that Resident 1's Representative was made aware of the additional low blood pressure and new treatment order. The NHA indicated that Employee 4 said that they missed writing the note. The NHA also indicated that Resident 1's Representative was present when their first low blood pressure was obtained on May 22, 2024, and that Resident 1's Representative was there 24/7. He indicated that notifications should be made and documented in a Resident's clinical record.</p> <p>During an interview with Resident 1's Representative on June 18, 2024, at 10:19 AM, she stated that she was not aware of Resident 1's low blood pressures or that a new medication was ordered for the low blood pressure.</p> <p>On June 20, 2024, at 11:51 AM, the NHA was provided the Immediate Jeopardy template and an immediate action plan was requested to ensure that physicians/CRNP's are notified timely of changes in a resident's condition.</p> <p>The facility provided a plan of action at 5:15 PM. The facility was notified at 5:25 PM that the action plan was accepted.</p> <p>The plan of action included: 1) Running an exception report to identify abnormal pressures of any other resident that may be at risk of a change in condition and notifying the physician of any residents that triggered on the report; 2) Education would be provided to nursing staff that all clinical information will be entered into the electronic medical record; 3) Education would be provided to nursing staff on the facility's Change in Condition policy and adherence to the policy; 4) Education would be provided to nursing staff (Registered Nurses and Licensed Practical Nurses) to notify physicians/CRNP's of change in condition/abnormal values; 5) Education would be provided to nurse aides to report vital signs to licensed nursing staff; and 6) Education was provided to staff currently working and staff not currently working at the facility will be called and educated before working their next shift.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On June 20, 2024, at 5:15 PM, interviews with staff, review of education, and review of the exception report revealed the facility had run the exception report and it had been reviewed and signed by Employee 1. Interviews were conducted with one Registered Nurse, four Licensed Practical Nurses, and five Nurse Aides; all were able to verbalize their role in monitoring, reporting, and documenting a resident's change in condition.</p> <p>On June 20, 2024, at 5:45 PM, the Immediate Jeopardy was lifted.</p> <p>The nursing staff failed to notify Resident 1's physician of the repeated low blood pressures and overall decline in condition. This resulted in a delay in physician assessment and oversight and a delay in treatment.</p> <p>201.14(a) Responsibility of licensee</p> <p>201.18(b)(1) Management</p> <p>211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46253</p> <p>Based on facility policy review, clinical record review, hospital record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided after a change in condition for one of 16 residents reviewed (Resident 1). This failure resulted in continued decline, which required hospitalization for hypovolemic shock (emergency condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body), low blood pressure, and cardiac arrest for Resident 1. This failure placed an additional six out of six residents reviewed who were identified as having a change in condition in an immediate jeopardy situation (Residents 9, 12, 13, 14, 15, and 16). The facility also failed to monitor blood glucose levels for residents with Diabetes Mellitus for two of 16 residents reviewed (Resident 1 and 9).</p> <p>Findings include:</p> <p>Review of facility policy, titled Change of Condition, with a last revision date of February 22, 2024, revealed the following: It is the policy of the Facility to inform residents, physician/CRNP's (Certified Registered Nurse Practitioners), and resident representatives of a change in the resident's condition; Licensed nursing staff will: 1. Evaluate any changes noted through direct observation or by assigned staff or any changes noted in report at change of shift or as noted on 24 Hour Report; 2. Obtain a complete set of vital signs (temperature, pulse respirations, and blood pressure) at the onset of the change and/or more often as appropriate or ordered by the physician/CRNP; 5. Notify the physician/CRNP immediately if the condition appears serious; 6. Notify the resident's representative of the change and any changes made to the resident's plan of care; 7. Address the change on the 24 Hour Report or facility specific form at the nursing station for follow through by the next shift; and 9b. Licensed staff will document findings in the EHR (electronic health record) regarding the change of condition and observations.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and hypertension (elevated blood pressure).</p> <p>Review of Resident 1 physician orders revealed orders for Lantus SoloStar Subcutaneous Solution Pen-injector 100 units/milliliters (Insulin Glargine-injectable medication to treat high blood sugars) Inject 8 units subcutaneously one time a day for Type 2 Diabetes Mellitus, dated May 14, 2024; and Midodrine HCl Oral Tablet 2.5 MG Give one tablet by mouth three times a day for hypotension dated May 23, 2024. Further review of Resident 1's physician order history revealed an order for Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/milliliters (Insulin Degludec-injectable medication to treat high blood sugars) inject 8 unit subcutaneously one time a day for DM, ordered on April 11, 2024, and discontinued on May 15, 2024. There were no orders noted for blood sugar monitoring.</p> <p>Review of Resident 1's physician visit note dated April 12, 2024, revealed that Resident 1 had a FreeStyle Libre 3 sensor (a device used for continuous glucose monitoring).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's clinical record revealed that blood glucose monitoring was not occurring. There were no routine blood glucose readings documented during Resident 1's admission to the facility, from April 11, 2024, through May 24, 2024. On May 24, 2024, Resident 1 was documented as having a change in condition and was subsequently transferred to the hospital. At that time, Resident 1's blood glucose was checked and it was 552 (normal is 70-100).</p> <p>During an interview with Employee 5 (Licensed Practical Nurse) on June 20, 2024, at 10:08 AM, Employee 5 stated that the facility does not use the FreeStyle Libre blood glucose monitoring.</p> <p>During an interview with the Director of Nursing (DON) on June 20, 2024, at 3:30 PM, she stated that the facility does use the FreeStyle Libre monitors, and that the facility has a written policy on their use. The policy was requested but was never provided to the surveyor, as of June 20, 2024, at 5:45 PM.</p> <p>Review of Resident 9's clinical record revealed that they were admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus with Foot Ulcer, and hypertension (high blood pressure).</p> <p>Review of Resident 9's physician orders revealed orders for metformin hydrochloride tablet (oral medication to manage blood sugar) 1000 milligrams give one tablet by mouth twice daily for Type 2 Diabetes Mellitus dated June 9, 2024; and Trulicity Subcutaneous Solution Pen-injector 4.5 milligrams/0.5 milliliters (duglatide) inject 0.5 milliliters subcutaneously weekly on Wednesday for Type 2 Diabetes Mellitus, dated June 9, 2024.</p> <p>Review of Resident 9's hospital referral records provided to the facility on [DATE], revealed that Resident 9's blood sugar was monitored before every meal and nightly.</p> <p>Further review of Resident 9's clinical record and orders failed to reveal any orders or documentation of the monitoring of Resident 9's blood sugar levels since their admission to the facility on [DATE].</p> <p>During an interview with the NHA on June 20, 2024, at 5:30 PM, he confirmed that Resident 9 had not been receiving blood sugar monitoring and that a new order had been obtained that day to monitor Resident 9's blood sugar levels.</p> <p>Review of Resident 1's nursing progress note dated May 22, 2024, at 1:30 PM, revealed that Resident 1 was complaining of not feeling well and stating that she felt full. Blood pressure 85/58 (normal is 120/80), abdomen was large, soft, and non-tender, and the Resident denied nausea and pain. The note further indicated that Resident 1 was given ginger ale soda and added to alert charting and the physician list.</p> <p>During an interview with the DON on June 17, 2024, at 12:44 PM, the DON indicated that alert charting was a facility process where a resident with any changes or concerns gets put into the book and that each shift nursing staff will make notes if they are having symptoms. She indicated that the book is at the nurse's station and has in it what the nurses are to monitor for and then the nursing staff will document their findings in the electronic health record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On June 17, 2024, at 1:18 PM, the DON stated when a resident is added to the physician list, it means the physician will see them the next time they are in the building. She further stated that the nurse practitioner comes in on Tuesdays and Fridays, so Resident 1 would have been seen on Friday, May 24, 2024.</p> <p>Review of Resident 1's nursing progress note dated May 22, 2024, at 6:10 PM, revealed Assessment completed on resident after CNA [certified nurse aide] stated she was more difficult to transfer than usual. Assessment completed all unremarkable except resident had hypoactive bowel sounds. Day two of no BM [bowel movement] after having a medium on 5/20. Resident is to [see] MD in AM to assess changes noted today. Neurologically intact. Stated that she does feel less full than this AM and did state that she was going to attempt to eat PM meal. Continue with current POC [plan of care], monitor anticipate needs.</p> <p>Review of Resident 1's nursing progress note dated May 23, 2024, at 5:15 AM, revealed Resident has had no complaints r/t [related to] not feeling well/poor appetite this shift. Will continue to monitor. The note did not address the low blood pressure.</p> <p>There were no other nursing progress notes noted between May 23, 2024, at 5:15 AM, and May 24, 2024, at 11:15 AM, indicating the monitoring of Resident 1's identified changes. In addition, the note on May 22, 2024, at 6:10 PM and the note on May 23, 2024, at 5:15 AM, failed to reveal any documentation regarding Resident 1's blood pressure.</p> <p>Review of Resident 1's nursing progress note dated May 24, 2024, revealed that the RN (Registered Nurse) noted the following vital signs: Temperature 96.6; pulse 60 and regular; respirations 12; blood pressure 106/52; pulse ox 84% on room air.</p> <p>Further review of Resident 1's progress notes revealed Employee 1 (Nurse Practitioner) reported that resident was confused and lethargic. Upon assessment, resident was gray in color and diaphoretic. Denies pain. Resident slowly to respond. Resident kept closing her eyes. BS [blood sugar] 552 [normal is 70-100]. Resident unable to state what was wrong. A new order was received to send Resident 1 to the emergency department. The Facility called 911 and Resident 1 left the facility via ambulance at 7:40 AM.</p> <p>Review of Resident 1's EMS (Emergency Medical Services) record, dated May 24, 2024, revealed that, upon arrival to the facility, the RN told EMS that Resident 1 had been hypotensive (low blood pressure), very pale, clammy, and had an altered mental status for two days. The RN stated that Resident 1's blood sugar was 552 on the morning of May 24, 2024, no insulin was given, and that no other glucose readings were documented during Resident 1's admission to the facility. The EMS report further noted that the RN stated Resident 1's blood pressure was in the 60's over the 40's over the past two days. Initial blood pressure from EMS at 7:34 AM was 82/51. It was also noted on assessment that Resident 1 was very cold and very pale as if in a GI bleed.</p> <p>Further review of the EMS report for Resident 1 revealed the following blood pressure readings:</p> <p>7:48 AM 72/43</p> <p>7:52 AM 85/59</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>7:57 AM 86/63</p> <p>8:03 AM 81/58.</p> <p>Review of Resident 1's hospital records dated May 24, 2024, revealed that they arrived at the emergency department at 8:06 AM, and was being treated for shock, hypotension (low blood pressure), gastrointestinal bleeding, and acute kidney injury. Resident 1 was noted to be profoundly pale, clammy to touch, with a low blood pressure of 84/64. At 9:08 AM, Resident 1 was noted to have no pulse and resuscitation efforts were initiated but were unsuccessful.</p> <p>Review of the alert charting list dated May 2024 revealed that Resident 1 had been entered on the list on May 22, 2024, on day shift for not feeling well, decreased appetite, and low blood pressure. The list further revealed the following:</p> <ol style="list-style-type: none"> <li>1) on May 22, 2024, evening shift was blank;</li> <li>2) on May 23, 2024, night shift had initials entered and day and evening shift were blank;</li> <li>3) on May 23, 2024, all shifts were blank; and</li> <li>4) on May 24, 2024, the night shift was blank.</li> </ol> <p>Review of Resident 1's nursing progress notes revealed there were no corresponding nursing progress notes for the alert charting, with the exception of a note on May 22, 2024, evening shift and a note on May 23, 2024, night shift.</p> <p>On June 17, 2024, at 1:18 PM, the DON provided daily assignment sheets for review, which are not part of the clinical record, but did reflect Resident 1's low blood pressures.</p> <p>Review of the facility form, titled Daily Assignment Sheet, revealed Resident 1 had the following blood pressures documented on the form:</p> <p>May 22, 2024, 10 PM-6 AM shift- 120/60</p> <p>May 23, 2024, 6 AM-2 PM shift- 80/60</p> <p>May 23, 2024, 2 PM-10 PM shift- 80/58.</p> <p>Review of Resident 1's clinical record revealed the aforementioned blood pressures were not documented in Resident 1's clinical record and there is no evidence that the provider was made aware of those blood pressures.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Transitions Healthcare Shook Home		STREET ADDRESS, CITY, STATE, ZIP CODE  55 South Second Street Chambersburg, PA 17201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview with Employee 1 on June 18, 2024, from 8:30 AM to 8:37 AM, Employee 1 confirmed that Resident 1 was started on Midodrine (medication to treat low blood pressure) after notification of a low blood pressure. Employee 1 stated that she was only aware of one low blood pressure and then she was told that Resident 1's blood pressure went back up. Employee 1 stated, .if I knew [Resident 1] was running in the 80's on multiple occasions, it may have changed the treatment course. Employee 1 indicated that when she arrived to visit Resident 1 on May 24, 2024, she noted a change in Resident 1's condition and gave the order to send Resident 1 to the hospital.</p> <p>Review of Resident 1's clinical record revealed that the 80/60 blood pressure on May 23, 2024, was not documented in Resident 1's clinical record and there was no evidence that Employee 1, or any other provider, was made aware of the low blood pressure.</p> <p>During a phone interview with the Nursing Home Administrator (NHA) on June 18, 2024, at approximately 10:00 AM, the NHA stated that they placed Resident 1 on charting and the physician list to be checked. The NHA indicated that he had spoken with Employee 4 (Registered Nurse) and that it was his understanding that when Employee 4 called Employee 1, Resident 1 was placed on alert charting, both low blood pressures were shared, and Employee 1 ordered a medication to treat the low blood pressure. During this conversation, it was shared with the NHA that Employee 1 indicated that they were not informed of the multiple low blood pressures and that there was no documentation in Resident 1's clinical record that Employee 1 was made aware of the blood pressures, that a treatment order was obtained, or that Resident 1's Representative was made aware of the additional low blood pressure and new treatment order. The NHA indicated that Employee 4 said that they missed writing the note.</p> <p>During an interview with Employee 4 on June 20, 2024, at 9:49 AM, Employee 4 indicated they had received reports on the afternoon of May 22, 2024, from nurse aides and therapy that Resident 1 was not acting right and was not feeling well. Resident 1's blood pressure was noted to be 85/58, but all other assessment findings were within normal limits. Employee 4 confirmed that she did not speak to Resident 1's physician/CRNP (Certified Registered Nurse Practitioner). Employee 4 further stated that on May 23, 2024, Resident 1 still said that she did not feel well. Employee 4 said that she took Resident 1's blood pressure after she returned from an activity, and it was 80/60. Employee 4 then said that when Employee 1 came in to assess Resident 1 on May 24, 2024, in the early morning, Employee 1 called Employee 4 to Resident 1's room because Resident 1 was confused and lethargic. Employee 4 indicated that Resident 1 was gray in color and diaphoretic (sweaty) and slow to respond but denied pain. Employee 4 said that Resident 1 appeared as if she might be experiencing a cardiac (heart) related issue.</p> <p>Review of the clinical record revealed no documented blood pressure on May 23, 2024.</p> <p>During an interview with Employee 6 (Physical Therapy Assistant) on June 20, 2024, at 10:23 AM, Employee 6 indicated that they could not recall specific dates, but remembered that Resident 1 was noted to decline in therapy participation and was not doing as well as when the Resident was first admitted .</p> <p>Review of Resident 1's physical therapy treatment notes revealed a note dated May 21, 2024, at 3:09 PM, that indicated Resident 1 was completing multiple trials of sit to stands and transfers with moderate assistance of one person to rise and was making attempts with grab bars/railing with minimal assistance of one person.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's physical therapy treatment notes revealed a note dated May 22, 2024, at 2:29 PM, that indicated Resident 1 was attempting bed mobility with increased need for assistance, difficulty sitting on edge of bed, and increased assist during sit to stand trials.</p> <p>Review of physical therapy note dated May 22, 2024, at 3:31 PM, indicated that Resident 1 was requiring maximum assistance for sit to stand transfers.</p> <p>Review of Resident 1's physical therapy treatment note dated May 23, 2024, at 12:06 PM, indicated Resident 1 had been trialed standing in supported position, with evidence of decreased ability to stand upright and to stand pivot. The note further indicated that Resident 1 had poor alertness throughout the session and that Resident was being downgraded to a stand pivot disc with the assistance of two staff due to safety concerns.</p> <p>Review of Resident 1's occupational therapy treatment note dated May 22, 2024, at 4:01 PM, indicated Resident 1 tolerated standing two minutes with minimal assistance for safety.</p> <p>Review of Resident 1's occupational therapy treatment note dated May 23, 2024, at 10:33 AM, indicated Resident 1 attempted to engage in sit to stand transfers and stand pivot disc transfers, but was very lethargic and fatigued, requiring moderate to maximum assistance of two people. The note further indicated that Resident 1 was reporting that the Resident had a headache and did not feel well and that nursing was made aware.</p> <p>Review of facility's alert charting documentation, which reflected residents who had a change in condition revealed that Residents 9, 12, 13, 14, 15, and 16 were all on alert charting for additional monitoring on June 20, 2024, after a change in condition.</p> <p>On June 20, 2024, at 11:51 AM, the NHA was provided the Immediate Jeopardy template and an immediate action plan was requested to ensure that resident's were being assessed for and receiving adequate monitoring for changes in condition.</p> <p>The facility was notified at 5:25 PM that the action plan was accepted.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The plan of action included: 1) Running an exception report to identify abnormal pressures of any other resident that may be at risk of a change in condition and notifying the physician of any residents that triggered on the report; 2) any resident's identified at risk based on the exception report were added to alert charting; 3) Education would be provided to nursing staff that all clinical information will be entered into the electronic medical record; 4) Running a report to identify residents with a diabetic medication and cross check for blood sugar monitoring; 5) All residents identified as having a change in condition will have alert charting initiated; 6) All alert charting will be initiated by Registered Nurses or Licensed Practical Nurses and entered as orders on the Medication Administration Record for nursing staff to sign off and the order will include vital signs and/or blood sugars if needed; 7) Nurse Aides will obtain vital signs at the beginning of the shift and turned into the Licensed Practical Nurse to review. Any abnormal vital signs will then be rechecked by the Licensed Practical Nurse at that time and reported to the Registered Nurse for notification to the physician/CRNP; 8) Education would be provided to nursing staff (Registered Nurses and Licensed Practical Nurses) to identify any resident with diabetic medication if an order to monitor blood sugar should be obtained if not on the hospital discharge summary; 9) an audit had been completed of all residents on diabetic medication to ensure blood sugar monitoring is being completed; 10) Education to nursing staff (Registered Nurses and Licensed Practical Nurses) that all insulins must have a blood sugar entered into the insulin order; and 11) Education was provided to staff currently working and staff not currently working at the facility will be called and educated before working their next shift.</p> <p>On June 20, 2024, at 5:30 PM, interviews, review of education, and review of the exception report revealed the facility had run the exception report and that it had been reviewed and signed by Employee 1. Interviews were conducted with one Registered Nurse and four Licensed Practical Nurses; all were able to verbalize their role in obtaining vital signs, the facility Change in Condition policy, the new process to follow for alert charting, proper order entry for blood sugar monitoring, and documentation of all clinical information in the resident's clinical record. Interviews were conducted with five nurse aides, and all were able to verbalize their role in obtaining vital signs, reporting vital signs to the Licensed Practical Nurse and/or Registered Nurse, and reporting changes in a resident's condition.</p> <p>On June 20, 2024, at 5:45 PM, the Immediate Jeopardy was lifted.</p> <p>The facility failed to ensure care and services were provided to Resident 1 after a change in condition and failed to continue monitoring Resident 1's blood pressure, resulting in continued decline and hospitalization for hypovolemic shock, cardiac arrest, and death. At the time of the survey, this failure placed six additional residents on alert charting in an immediate jeopardy situation.</p> <p>201.14(a) Responsibility of licensee</p> <p>201.18(b)(1) Management</p> <p>211.12(d)(1)(2)(3)(5) Nursing services</p>		