STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395944	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chambers Pointe Health Care Center	1425 Philadelphia Avenue 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on a review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of four residents reviewed (Resident 2) resulting in a fall with a fracture.Findings include:The facility's abuse policy, dated February 20, 2025, revealed that the facility will not tolerate abuse and that facility staff must immediately report all such allegations to the Nursing Home Administrator/Abuse Coordinator.The facility's abuse policy, dated February 20, 2025,revealed that the facility provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of the resident's abilities and care needs) for Resident 2, dated April 29, 2025, revealed that the resident was cognitively intact, was understood, was able to understand others, had no impairment of the upper extremities, and required assistance for transfers.A nurse's note for Resident 2, dated July 11, 2025, at 8:00 p.m., revealed that the resident had a witnessed fall. The resident stated that she fell backwards. The staff person in the room indicated the resident was ambulating with a rollator and had assisted the resident from the bathroom to the bed. When the staff person side stepped to arrange the blankets on the bed the resident fell backwards. Resident 2 had complaints of 10 out of 10 pain of the right shoulder and was unable to perform range of motion due to the pain. The resident was transported to the hospital for evaluation of the right upper extremity pain.Information submitted by the facility, dated July 11, 2025, at 7:00 p.m., indicated that on July 11, 2025 at 5:00 p.m. Nurse Aide 1 was ambulating Resident 2 from the bathroom to the bed with a four wheeled walker. The nurse aide turned to pull the bed linen down and the resident lost her balance and fell backwards. Resident 2's right shoulder hurt. A gait belt was not in used during the fall. Resident 2 was sent the emergency room for evaluation and was noted to have a proximal Humerus fracture. The facility's investigation concluded that Nurse Aide 1 verbalized that she knew she should have used a gait belt prior to transfer, but she forgot. Resident 2's care plan prior to the fall and the gait belt policy indicated that a gait belt should have been used for ambulation and transfer, and was not used by the nurse aide. The findings of the investigation substantiated neglect.A nurse's note for Resident 2, dated July 16, 2025, at 1:42 a.m., revealed the resident was adjusting well to readmission to the facility. Resident 2 used a sling to the right shoulder due to a fracture and pain medication was used as needed for increased shoulder pain.A witness statement from Registered Nurse 2, dated July 11, 2025, revealed that she entered the room to see that Resident 2 was lying on her back leaning to the right and did not see a gait belt on the resident. Resident 2 complained of right shoulder pain and was unable to move her right arm.A witness statement from Nurse Aide 1, dated July 11, 2025, revealed that she was providing care for Resident 2 and while walking back to the bed the resident called out that she was falling as I used my right hand to pull the sheets back from the bed. Resident 2 was not wearing a gait belt at this time. The resident fell to the ground.Interview with the Nursing Home Administrator on August 8, 2025, at 11:09 a.m. revealed that she substantiated neglect and terminated the employee for not using a gait belt.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 201.29(j) Resident Rights.28 Pa. Code 211.12 (d)(5) Nursing Services.