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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chambers Pointe Health Care Center	1425 Philadelphia Avenue Chambersburg, PA 17201

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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. 48809 Based on observations and review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to make ongoing efforts to resolve a grievances. Findings include: A meeting with a group of residents on March 11, 2024, at 10:37 a.m. revealed that the food was cold, unappetizing and unpalatable. A grievance filed on November 14, 2023, revealed that a resident received cold food on November 11, 2023, and November 12, 2023. A grievance filed on February 7, 2024, revealed that Resident 8 continued to receive cold food. Observations of the lunch meal service on March 12, 2024, at 10:52 a.m. in the Evergreen dining room revealed the following temperatures at the beginning of service: the pasta and butter sauce was 152 degrees Fahrenheit (F), the popcorn chicken was 143.0 degrees F, the shrimp was 173.0 degrees F, the mashed potatoes were 160.0 degrees F, the beets and carrots were 164.0 degrees F, the mechanical chicken was 163.0 degrees F, and the mechanical shrimp was 156.0 degrees F. After the last resident was served lunch in the Evergreen dining room on March 12, 2024, at 12:26 p.m. a test tray was conducted. The pasta with shrimp and butter sauce was 136.0 degrees F and tasted cold, the mashed potatoes with gravy was 133.0 degrees F and tasted cold, the carrots and beets were 131.0 degrees F and tasted cold, the mechanical chicken was 135.0 degrees F and tasted cold, and the mechanical shrimp was 137.0 degrees and tasted cold. Interview with the Nursing Home Administrator on March 12, 2024, at 4:32 p.m. confirmed that cold food has been an ongoing concern and that it was not resolved based on continued grievances and cold test tray. 28 Pa. Code 201.29(i) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.

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 - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42079 Based on review of clinical records and staff interviews, it was determined that the facility failed to notify the resident's representative in writing regarding the reason for hospitalization for one of 30 residents reviewed (Resident 38). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 38, dated January 30, 2024, indicated that the resident was severely cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included stroke and traumatic brain injury. Resident 38's daughter was listed in the clinical record as the responsible party and first emergency contact. MDS discharge assessments for Resident 38, dated October 13 and 19, 2023, and November 4, 2023, revealed that the resident was admitted to the hospital on those dates. Nursing notes for Resident 38, dated October 13 and 19, 2023, and November 4, 2023, indicated that the resident was transferred to the hospital for further evaluation, treatment and admission. There was no documented evidence in Resident 38's clinical record to indicate that the resident's representative was notified in writing of the purpose for the resident's transfer about the hospitalization s in October and November 2023. Interview with the Nursing Home Adminstrator on March 12, 2024, at 4:19 p.m. confirmed that there was no documentation that the resident's representative was notified in writing of Resident 38's transfers and hospitalization s in October and November 2023, and there should have been. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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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. 48809 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 30 residents reviewed (Resident 21). Findings include: A facility policy for care planning, dated September 14, 2023, revealed that assessments of residents were ongoing and that care plans were revised as information about the residents' conditions change. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 21, dated January 10, 2024, revealed that the resident was sometimes understood and could usually understand others, was cognitively impaired, and was dependent on staff for daily care needs. A care plan for Resident 21, updated January 10, 2024, revealed that the resident had inadequate oral intake with swallowing difficulty and unintended weight loss. There was nothing in the care plan to indicate that Resident 21 refused dinner trays. A note from speech therapy, dated January 25, 2024, revealed that Resident 21 can have a mechanically soft diet if resident is alert, out of bed, and in the dining room. A note from dietary, dated February 13, 2024, revealed that Resident 21 continues to refuse her dinner tray. Nursing notes for Resident 21 revealed that the resident refused dinner trays on February 14, February 17, February 18, February 22, February 26, and March 8, 2024. Interview with Speech Therapist 1 and Speech Therapist 2 on March 12, 2024, at 1:16 p.m. revealed that they were made aware on March 8, 2024, that Resident 21 continues to refuse dinner trays and is on the case load to evaluate safety to remain in bed while eating. Interview with Nursing Home Administrator on March 12, 2024, at 1:31 p.m. revealed that the care plan needed to be updated to reflect resident's continued refusals of supper trays. 28 Pa. Code 201.24(e)(4) Admission Policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42079 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond timely to a pharmacy recommendation for one of 30 residents reviewed (Resident 36). Findings include: The facility's policy for pharmacy services, dated September 14, 2023, revealed that the licensed pharmacist will collaborate with facility leadership and staff to coordinate pharmaceutical services within the facility, guide development and evaluation of pharmaceutical services procedures, and help the facility identify, evaluate, and resolve pharmaceutical concerns which affect resident care and medical care, or quality of life. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated August 11, 2023, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included atrial fibrillation (irregular heartbeat), high blood pressure, high cholesterol, thyroid disorder, arthritis, and renal failure. Physician's orders for Resident 36 on admission, dated January 19, 2023, included orders for the resident to receive 7.5 milligrams (mg) of Meloxicam (nonsteroidal anti-inflammatory pain medication) twice a day for pain, 20 milliequivalent (meq) of potassium chloride daily for low potassium levels, 25 mg of Losartan (high blood pressure medication) daily for high blood pressure, 50 micrograms (mcg) of Levothyroxine daily for low thyroid levels, 300 mg of Allopurinol (uric acid lowering medication) daily for gout (high uric acid level causes arthritis), and 20 mg of lasix (diuretic medication) for edema. Review of the pharmacy medication regime review (MRR) for Resident 36, dated September 27, 2023, revealed recommendations to have blood draws for laboratory testing that included a basic metabolic panel for taking an angiotensin receptor blocker (a type of high blood pressure medication) every six months, a lipid panel yearly for taking a statin (cholesterol lowering medication), an uric acid level yearly when taking Allopurinol, and a thyroid stimulating hormone level yearly for taking Levothyroxine (synthetic thyroid medication). The MRR recommendation was never reviewed, responded to, or signed by the physician to agree or disagree. Review of a pharmacy MRR for Resident 36, dated November 6, 2023, revealed recommendations to have blood draws for laboratory testing that included a complete metabolic panel for taking furosemide (Lasix), Meloxicam, potassium medication, and Losartan every six months; a full lipid panel yearly for taking a statin; and an uric acid level yearly when taking Allopurinol. The MRR recommendation was never reviewed, responded to, or signed by the physician to agree or disagree. Interview with the Director of Nursing on March 13, 2024, at 3:41 p.m. confirmed that the pharmacy MRR recommendations for Resident 36 were not addressed by the physician and should have been. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on observations and staff interviews, it was determined that the facility failed to ensure that controlled medications were stored in a separately-locked, permanently-affixed compartment in one of two medication rooms reviewed (Main), and failed to discard expired medical supplies in one of two medication rooms reviewed (Evergreen). Findings include: Observations in the Main medication room refrigerator on [DATE], at 8:12 am. revealed that there was a narcotic storage box containing an unopened bottle of liquid Ativan (a controlled medication used to treat anxiety) and the box was not permanently affixed inside the refrigerator. An interview with Registered Nurse 1 on [DATE], at 8:14 a.m. confirmed that the narcotic storage box containing the bottle of Ativan should have been permanently affixed inside the Main medication room. Observations in the Evergreen medication room on [DATE], at 8:17 a.m. revealed that there were multiple intravenous catheters (medical supplies used in the vein to provide fluids or medication) that expired in February, September and December of 2023, and three syringes that expired in [DATE] and [DATE]. An interview with Registered Nurse 1 on [DATE], at 8:19 a.m. confirmed that the medical supplies were expired and should not have been in circulation to be used on residents. Interview with the Nursing Home Administrator on [DATE], at 3:24 p.m. confirmed that the facility had no policy that spoke to expired medical supplies or narcotic boxes being permanently affixed in the medication refrigerator. Furthermore, she confirmed that the narcotic storage box containing Ativan was not permanently affixed inside the refrigerator and expired medical supplies were in circulation, and they should not have been. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41233 Based on a review of facility's policies and observations, as well as resident and staff interviews, it was determined that the facility failed to serve food items that were palatable and at proper temperatures. Findings include: The facility's policy regarding Food Handling Principles dated September 14, 2023, revealed that hot foods are to be served at 135-155 degrees Fahrenheit (F). Observations on March 12, 2024, at 10:52 a.m. revealed that the food was brought to the kitchenette and initial temperatures were taken. The pasta was 152.0 degrees F, the popcorn chicken was 143.0 degrees F, the shrimp was 173.0 degrees F, the mashed potatoes were 160.0 degrees F, the beets and carrots were 164.0 degrees F, the mechanical chicken was 163.0 degrees F, and the ground shrimp was 156.0 degrees F. The food was then placed in the steam table. The steam table pans containing the hot food were left uncovered throughout the lunch meal service. After serving lunch to the last resident in the dining room on March 12, 2024, at 12:26 p.m., temperatures for a test tray were obtained. The mechanical shrimp was 137.0 degrees F and cold to taste, the mechanical chicken was 135.0 degrees F and cold to taste, the carrots and beets were 131.0 degrees F and cold to taste, the mashed potatoes with gravy were 133 degrees F and cold to taste, the shrimp with pasta and garlic butter was 136.0 degrees F and cold to taste. Interview with Dietary Aide 4 on March 12, 2024, at 12:26 p.m. revealed that the lids should have been closed when not plating food. Interview with the Nursing Home Administrator on March 12, 2024, at 2:16 p.m. confirmed that food should be served at an appropriate temperature, and that the food would be cold if lids are left open during service. 28 Pa. Code 211.6(b) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48809 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to serve food in accordance with professional standards for food service safety, by failing to ensure that dietary staff wore hair coverings that completely covered their hair during food handling and not storing food properly. Findings include: The facility's dietary policy regarding Use of Hair Restraints, dated September 14, 2023, revealed that staff were to wear a hat or hairnet to cover all visible hair. The facility's dietary policy regarding Food Storage, dated September 14, 2023, revealed that food is stored in a manner that prevents damage, spoilage, infestation, and bacterial contamination. Observations in the main kitchen on March 11, 2024, at 10:26 a.m. revealed that the Assistant Dietary Director was wearing a hair restraint and approximately three inches of her bangs were uncovered. Observations in the freezer on March 11 2024, at 10:26 a.m. revealed a tray containing 22 uncovered, unlabeled and undated grey colored, unidentifiable food patties; 24 patties of pureed cranberry that was uncovered, unlabeled and undated; and a full box of [NAME] that was uncovered, undated and unlabeled and open to the air. Observations in the Evergreen kitchenette on March 11, 2024, at 10:41 a.m. revealed that Dietary Aide 5 exited the kitchenette without a hairnet. Observations in the Dogwood kitchenette on March 11, 2024, at 10:45 a.m. revealed that Dietary Aide 6 had three inches of hair on the back of her head that was not covered by her hair restraint. Interview with the Executive Culinary Director on March 11, 2024, at 10:46 a.m. confirmed that staff did not have all hair covered with hair restraints and should have, and that the frozen patties and box of [NAME] were not covered and dated and should have been. 28 Pa. Code 211.6(f) Dietary Services.