

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Menno Haven Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2055 Scotland 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that a physician's order was obtained to provide specialized respiratory treatment for one of 25 residents reviewed (Resident 45). Findings include: The facility policy for non-invasive ventilation (CPAP-continuous positive airway pressure used to provide patent airway during periods of sleep apnea (breathing repeatedly stops and starts during sleep), dated January 8, 2025, revealed that the facility was to obtain an order for the use of the CPAP device and settings from the practitioner. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 45, dated July 30, 2025, revealed that the resident was cognitively intact and used non-invasive ventilation. A care plan for the resident, dated July 23, 2025, revealed that the resident was to use CPAP per the physician's order. A nursing note, dated July 29, 2025, at 1:55 p.m. revealed that Resident 45 used CPAP at bedtime. There was no documented evidence that a physician's order was obtained to use the CPAP machine at bedtime. Interview with the Director of Nursing on August 12, 2025, at 1:15 p.m. confirmed that there was no documented evidence that there was a physician's order for Resident 45 to use CPAP. 28 Pa. Code 211.12(d)(3)(5) Nursing services.</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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of facility policies and observations, as well as resident and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures. Findings include: The facility's current policy regarding food temperatures, dated January 8, 2025, indicated that a tray line point of service standard for cold food must be held at a temperature of 31-41 degrees Fahrenheit (F) and hot food between 155-170 degrees F. A delivery standard for cold food must be served at a temperature between 33-50 degrees F and hot food at 135-155 degrees F. Interview with Resident 38 on August 11, 2025, at 11:30 a.m. included that the resident stated, the food is always cold when I get it. Interview with Resident 35 on August 11, 2025, at 12:10 p.m. included that the resident stated, the food just doesn't seem to stay hot. Interview with Resident 37 on August 11, 2025, at 12:30 p.m. included that the resident stated, the food would taste much better if it wasn't always cold. The menu for Wednesday (undated) revealed that the lunch meal included cold Italian couscous salad, macaroni and cheese, stewed tomatoes, dinner roll and a glazed blueberry lemon cake. The food production log, dated August 13, 2025 revealed that at 11:15 a.m. the temperature of the macaroni and cheese was 184 degrees F and the stewed tomatoes was 168 degrees F. Observations in the main kitchen service area on August 13, 2025, revealed that the Coastal Way cart left the main kitchen at 12:40 p.m. and arrived on the Coastal Way unit. Trays were passed to the residents in their rooms and the last resident was served at 12:42 p.m. At 12:42 p.m. the temperature of the macaroni and cheese was 126.3 degrees F, and the temperature of the stewed tomatoes was 130.8 degrees F. The macaroni and cheese and stewed tomatoes were lukewarm and did not taste appetizing. Interview with [NAME] 1 on August 13, 2025 at the time of the observation confirmed that the macaroni and cheese and stewed tomatoes should have been hotter. 28 Pa. Code 211.6(b) Dietary Services.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of policies and clinical records, as well as interviews with residents, family members, and staff, it was determined that the facility failed to maintain professional practices that support infection prevention and control for one of 25 residents reviewed (Resident 35). Findings include: The facility's policy regarding hand hygiene, dated January 8, 2025, indicated that all team members will be trained and complete hand hygiene competencies at regular in-service on the importance of hand hygiene in preventing the transmission of healthcare-associated infections upon hire and no less than annually. Staff are to use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap at times that include before and after handling clean or soiled dressings, gauze pads, etc., after removing gloves, and before and after entering isolation precautions settings. The use of gloves does not replace hand washing/hand hygiene. The facility's Wound Care Observation Checklist for Infection Control, completed by Registered Nurse 2 on June 10, 2025, revealed that best practices for infection control during wound dressing changes indicated that hand hygiene is to be performed properly before preparing a clean field. A clean field is prepared when the surface is wiped with antiseptic wipes following manufacturer's guidelines, a surface barrier is applied (e. g., chux (absorbent pads, often used to protect surfaces like beds, chairs, and furniture from fluids)pads) and supplies are placed on the surface barrier in aseptic manner Hand hygiene is performed before starting the procedure, a barrier is positioned under the wound, the old dressing is removed and discarded, the dirty gloves are removed and discarded, and hand hygiene is applied before accessing the clean supplies, and clean gloves are donned. Gloves are removed and hand hygiene is performed properly after dressing change is complete. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated August 2, 2025, indicated that the resident was understood and usually able to understand others, required assistance for daily care needs, had diagnoses that included after care for fracture of the right lower leg, and had a skin tear. Physicians' orders for Resident 35 dated August 8, 2025, included an order to cleanse the skin tear on the right lower extremity with normal saline and apply xeroform gauze then cover with gauze pads and wrap with Kerlix, may place abdominal pad to back of leg for additional padding every day shift. Physician's orders for Resident 35 dated August 10, 2025, included an order to cleanse the skin tear on the left shin with normal saline and apply xeroform gauze then cover with gauze pads and wrap with Kerlix every day shift. Observations on August 13, 2025, at 2:42 p. m. revealed that Registered Nurse 2 took wound care supplies into Resident 35's room, placed them on her dresser in the room and donned a gown and gloves. She removed Resident 35's left lower extremity dressing, removed her gloves, used alcohol-based hand rub and reapplied gloves. She moved the dressing supplies from the dresser and placed the gauze pads, and xeroform (medicated petrolatum gauze dressing,) dressings unopened onto the floor in Resident 35's room, opened the supplies from the floor to cleanse the resident's skin tear. She then picked up the Xeroform dressing package from the floor and cut a piece off and applied it the resident's leg, added a gauze pad and padding to the back of her leg and wrapped kerlix around the leg. She removed her gloves and applied tape to the dressing. Registered Nurse 2 then proceeded to take the CAM (Controlled Ankle Motion boot - used to immobilize and support the ankle after an injury) boot off the resident's right leg, applied gloves and removed the old dressing. She then removed her gloves, applied new gloves, opened the gauze sponge packaging that she had laying on the floor and cleansed the skin tear with saline, removed her gloves, went to her treatment cart to get more gauze pads, used hand sanitizer, and applied new gloves. She then cleansed the skin tear some more, removed her gloves, and applied clean gloves, used skin prep to the area surrounding the skin tear, removed her gloves, donned clean gloves, used the package of Xeroform that was on the floor and applied xeroform to two areas, and removed her gloves. She then repositioned the resident's leg, applied new gloves, applied gauze pad, wrapped the leg with kerlix, taped the dressing, applied pads to top and back of the resident's leg and reapplied the CAM boot. Registered Nurse 2 then removed her gloves and gown and washed her hands and cleansed her scissors and removed the garbage from the room to the soiled utility room and used hand sanitizer. There was no observation that a clean field for wound care dressings was used, that a barrier was positioned under the resident's wound, or that hand hygiene was performed every time the nurse removed her gloves. Interview with Registered Nurse 2 on August 13, 2025, at 3:28 p.m. revealed that she thought she probably should have performed hand hygiene between glove changes. Interview with the Director of Nursing on August 13, 2025, at 3:52 p.m. revealed that Registered Nurse 2 should have performed hand</p>		