

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Concordia at Spiritrust Luther Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 2781 Luther Drive Chambersburg, PA 17202	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure physician orders were followed for catheter care for one of one resident reviewed for catheters (Resident 8). Findings include: Facility policy, titled Catheter Care, Urinary, last reviewed January 2026, read, in part, The purpose of this procedure is to prevent infection of the resident's urinary tract. Catheter care is to be done every shift and as necessary. Review of Resident 8's clinical record revealed diagnoses that included dementia (decline in mental ability severe enough to interfere with daily life) and obstructive and reflux uropathy (blockage of the urinary tract that causes urine to back up into one or both kidneys). Review of Resident 8's physician orders revealed an order for foley catheter: document color, clarity, sediment, odor every shift related to obstructive and reflux uropathy. Review of Resident 8's treatment administration records for May 2026 and June 2026 revealed that there was no documentation for foley catheter: document color, clarity, sediment, odor every shift on the following dates and shifts: day shift - May 2, 3, 4, 6, 12, 27, and June 1; evening shift - May 1, 2, 3; and night shift - May 1, 2, 3. Review of Resident 8's point of care tasks revealed a task for catheter care every shift and as needed. Further review of Resident 8's task for catheter care for May 2026 and June 2026 revealed that there was no documentation that any catheter care was provided for the following dates and shifts: day shift - May 31 and June 2; evening shift - May 9, 30; and night shift - May 5, 6, 16, 24, 28, 30, 31 and June 4. During an interview with the Nursing Home Administrator (NHA) on June 11, 2026 at 10:09 AM, it was revealed that she had no additional information to provide. The NHA stated that it was the facility's expectation that physician orders be followed, that documentation be completed, and that catheter care be provided. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one residents reviewed receiving dialysis (Resident 41). Findings include: A review of the facility policy, titled Hemodialysis Resident Care Standard, last reviewed January 2026, revealed that staff were to complete the pre-dialysis portion of the Hemodialysis Communication Record that provided information regarding the resident's ongoing status to send with the resident to dialysis. The policy stated, Assure the interchange of information with the dialysis clinic useful/necessary for the care of the resident. Use Hemodialysis Communication Form (#806NSG). Clinical record review revealed that Resident 41 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis, and had a physician's order dated May 19, 2026, for the facility to provide dialysis three days per week. There was a lack of evidence to support that the pre-dialysis portion of the Resident's dialysis communication forms were completed or that the Resident was assessed before dialysis prior to any dialysis since May 19, 2026. A staff interview with Employee 1 (Registered Nurse) on June 10, 2026, at 11:25 AM, revealed there was no dialysis communication binder or folder for documentation to or from the dialysis center for Resident 41. Employee 1 said the family transports Resident 41 to and from dialysis and there was no documentation returned with the Resident or family to the facility. On June 10, 2026, the surveyor requested post-dialysis communication forms. The facility was unable to provide any post-dialysis communication forms. On June 11, 2026, at 10:10 AM, the surveyor was provided with copies of documentation from dialysis. The post-dialysis forms were never sent to the facility or requested by the facility until June 11, 2026. During an interview with the Nursing Home Administrator (NHA) on June 11, 2026, at 10:07 AM, regarding the facility Dialysis Policy not being followed for Resident 41, the NHA expressed the expectation for staff to follow the policy for effective communication with Dialysis regarding resident care pre and post dialysis treatments. 28 Pa. Code 211.12(1)(3)(5) Nursing services.		

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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. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed by a consultant pharmacist and responded to in a timely manner by the attending physician or prescriber for three of five residents reviewed (Residents 4, 7, and 8). Findings Include: Facility policy, titled Drug Regimen Review, last reviewed January 2026, read, in part, PROCEDURE: 1. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, physician and the care planning team. 2. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review (approximately 30 days) .3. Recommendations are acted upon and documented by the facility staff and/or the prescriber.5. The Director of Nursing keeps the consultant pharmacist's monthly reports on file for at least one year (annual survey to annual survey). Review of Resident 4's clinical record revealed diagnoses that included type 2 diabetes mellitus (the body resists the effects of insulin or doesn't produce enough insulin, causing high blood sugar) and atherosclerotic heart disease of native coronary artery (blood vessel supplying the heart becomes narrowed or blocked by plaque). Review of the pharmacy's medication regimen review documents failed to reveal documentation that Resident 4's medication had been reviewed for the months of July 2025, August 2025, October 2025, February 2026, March 2026, and May 2026. Further review of the pharmacy medication regimen review documents revealed recommendations were made April 2026. Review of the recommendations on the aforementioned date failed to reveal a physician response or signature. An interview with the Nursing Home Administrator (NHA) on June 11, 2026 at 10:05 AM, revealed that the facility had no additional information to provide and that it was the facility's expectation that pharmacy medication reviews to be completed monthly and recommendations be responded to timely by the physician. Review of Resident 7's clinical record revealed diagnoses that included dementia (decline in mental ability severe enough to interfere with daily life) and anxiety disorder (persistent and excessive worry or fear that is disproportionate to the situation and interferes with daily life). Review of the pharmacy's medication regimen review documents failed to reveal documentation that Resident 7's medication had been reviewed for the months of July 2025, August 2025, September 2025, October 2025, December 2025, and January 2026. Further review of the pharmacy medication regimen review documents revealed recommendations were made on March 12, 2026, and April 23, 2026. Review of the recommendations on the aforementioned dates failed to reveal a physician response or signature. An interview with the NHA on June 11, 2026 at 10:05 AM, revealed that the facility had no additional information to provide and that it was the facility's expectation that pharmacy medication reviews to be completed monthly and recommendations be responded to timely by the physician. Review of Resident 8's clinical record revealed diagnoses that included dementia and anxiety disorder. Review of the pharmacy's medication regimen review documents failed to reveal documentation that Resident 8's medication had been reviewed for the months of July 2025, September 2025, and October 2025. Further review of the pharmacy medication regimen review documents revealed that recommendations were made on August 19, 2025; January 19, 2026; and April 23, 2026. Review of the recommendations on the aforementioned dates failed to reveal a physician response or signature. An interview with the NHA on June 11, 2026 at 10:05 AM, revealed that the facility had no additional information to provide and that the NHA would expect pharmacy medication reviews to be completed monthly and pharmacy recommendations to be reviewed and responded to in a timely manner by the physician. 28 Pa. code 211.9 (a)(1) Pharmacy services28 Pa. Code 211.12(c)(d)(3)(5) Nursing services		

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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. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for two of 12 residents reviewed (Residents 4 and 7). Findings include: Facility policy, titled Comprehensive Care Planning Standard, last reviewed January 2026, read, in part, PROCEDURE: A. The care plan framework will include the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of Resident 4's clinical record revealed diagnoses that included type 2 diabetes mellitus (the body resists the effects of insulin or doesn't produce enough insulin, causing high blood sugar) and pressure ulcer of the right buttock, stage 3 (full-thickness skin wound, exposing the underlying fatty tissue). Review of Resident 4's weekly wound rounds notes revealed that Resident 4 had a chronic stage 3 pressure injury on the right buttock, acquired on August 1, 2025, and that Resident 4 was currently receiving treatment for the pressure injury. Review of Resident 4's comprehensive plan of care failed to reveal a focus area or interventions for skin impairment or pressure ulcer. During an interview with the Nursing Home Administrator (NHA) on June 11, 2026, at 10:05 AM, it was revealed that a focus area for skin impairment to include pressure ulcer and interventions had been added to Resident 4's care plan. The NHA stated it was the expectation of the facility that comprehensive care plans be developed accurately. Review of Resident 7's clinical record revealed diagnoses that included dementia (decline in mental ability severe enough to interfere with daily life) and anxiety disorder (persistent and excessive worry or fear that is disproportionate to the situation and interferes with daily life). Review of Resident 7's physician orders revealed medication orders for oxycodone (narcotic pain medication), Ativan (psychotropic, anti-anxiety medication), quetiapine fumarate (anti-psychotic medication), and escitalopram oxalate (psychotropic antidepressant medication). Further review of Resident 7's physician orders revealed an order for hospice evaluation and treatment. Review of Resident 7's comprehensive care plan failed to reveal any focus areas or interventions for receiving hospice services, antipsychotic medication use, narcotic medication use, and psychotropic medication use. During an interview with the NHA on June 11, 2026 at 10:05 AM, it was revealed that a new company had taken over on May 1, 2026, and that the facility was in the process of updating resident records. The NHA stated that Resident 7's comprehensive care plan had not been completed in the new company's system. The NHA stated it was the expectation of the facility that comprehensive care plans be developed in a timely manner. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(3)(5) Nursing services		