

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOFFER AVENUE CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 640702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on April 16, 2025, at Chambersburg Skilled Nursing and Rehabilitation Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 640702

SURVEY EXIT DATE: 04/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 640702 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on April 16, 2025, it was determined that Chambersburg Skilled Nursing and Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type III (211), protected ordinary structure, without a basement, which is fully sprinklered.	K 0000		
K 0291 SS=F		K 0291		

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TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0291 SS=F	Continued from page 1 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	1. and 2. Maintenance Director has completed annual maintenance of battery-powered emergency lighting and installed battery-powered emergency lighting at the automatic transfer switch. 3. Maintenance department will be educated on the standards of ensuring the facility has completed the annual maintenance of battery-powered emergency lighting and ensuring there is a battery back-up emergency lighting at the automatic transfer switch. 4. Maintenance or facility designee will audit the facilities battery-powered emergency lighting weekly x2 for 2 months, then every 60 days throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

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K 0291 SS=F	Continued from page 2 Based on document review, observation and interview, it was determined the facility lacked documentation, verifying the annual maintenance of battery-powered emergency lighting sources, and lacked an installed battery-powered emergency lighting, at the automatic transfer switch, affecting six of six smoke compartments within the component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, it was revealed the facility failed to provide documented annual testing of battery-powered emergency lighting sources. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the lack of documentation for installed back-up emergency lighting testing.	K 0291		

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K 0291 SS=F	Continued from page 3 2. Observation on April 16, 2025, at 11:50 AM, revealed the Automatic Transfer Switch lacked an installed battery back-up emergency light. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed there was no battery back-up emergency lighting, at the Automatic Transfer Switch.	K 0291		
K 0321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 0321	1 and 2. Maintenance Director installed astragal between the double doors in the boiler room. 3. Maintenance department will be educated on the standards of ensuring the facility's corridor doors do not have a gap greater than 1/2in. and to not remove astragal. 4. Maintenance or facility designee will audit the facilities corridor doors weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

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K 0321 SS=D	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors, to be smoke tight, in one of six smoke compartments within the component. Findings include: 1. Observation on April 16, 2025, at 11:55 AM, revealed a gap, greater than 1/2-inch, of the corridor doors, between the double doors, Boiler Room, due to removed astragal. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the Boiler Room door was not smoke tight.	K 0321		
K 0324 SS=C		K 0324		

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K 0324 SS=C	Continued from page 6 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	1 and 2. Maintenance Director completed the monthly check of the chemical fire suppression system. 3. Maintenance department will be educated on the standards to ensure we are checking the chemical fire suppression system monthly. 4. Maintenance or facility designee will audit facilities chemical fire suppression system to ensure it is checked off weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

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K 0324 SS=C	Continued from page 7 Based on document review and interview, it was determined the facility failed to provide owner's checks of the fixed chemical fire suppression system, in one of six smoke compartments within the component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, revealed the facility could not provide documentation of the owner's quick check for the fixed chemical fire suppression system installed in the Kitchen. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed lack of documentation of quick checks on the Kitchen's fixed chemical fire suppression system.	K 0324		
K 0345 SS=C		K 0345		

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K 0345 SS=C	Continued from page 8 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	1 and 2. Maintenance Director contracted Eastern Time, Inc. to revisit facility to complete semi-annual fire alarm system testing. 3. Maintenance department will be educated on the standards of the facilities fire alarm system inspection. 4. Maintenance or facility designee will audit facilities fire alarm system inspection located in the life safety book weekly x2 for 2 months then quarterly throughout the year to confirm fire alarm reports are still available for review and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

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K 0345 SS=C	Continued from page 9 Based on document review and interview, it was determined the facility failed to provide documentation, verifying the semi-annual testing and inspection of the fire alarm system had occurred, within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, revealed the facility failed to provide documentation, verifying semi-annual testing and inspection of the fire alarm system had occurred, within the previous twelve months. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the facility failed to provide documentation, verifying semi-annual testing and inspection of the fire alarm system had occurred, within the previous twelve months.	K 0345		

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K 0712 SS=C	<p>NFPA 101 Fire Drills</p> <p>Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0712	<p>1 and 2. Maintenance Director will complete monthly fire drills, one per shift, per quarter.</p> <p>3. Maintenance department will be educated on the standards of the facilities monthly fire drill policy ensuring they are being conducted one per shift, per quarter.</p> <p>4. Maintenance or facility designee will audit facilities fire drills to ensure it is checked off weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.</p>	<p>Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025</p>

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K 0712 SS=C	Continued from page 11 Based on document review and interview, it was determined the facility failed to conduct and perform fire drills, one per shift, per quarter, which serves the entire component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, revealed the facility did not perform fire drills, during the following: a. 1st quarter 2025, 2nd shift; b. 3rd quarter 2024, 1st shift; c. 3rd quarter 2024, 3rd shift. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the fire drills were not performed.	K 0712		
K 0741 SS=F		K 0741		

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K 0741 SS=F	Continued from page 12 NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 0741	1 and 2. Maintenance Director will print smoking policy for life safety binder, will post non-smoking signs in rooms, wards, or compartments where flammable liquids, combustible gases or oxygen is used or stored and will provide metal receptacles to be available where smoking is permitted. 3. Maintenance department will be educated on the standards of the facilities smoking policy, need for non-smoking signs, and providing metal receptacles where smoking is permitted. 4. Maintenance or facility designee will audit facilities smoking policy, metal receptacles, and non-smoking signs to ensure it is checked off weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

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K 0741 SS=F	Continued from page 13 Based on document review, observation and interview, it was determined the facility lacked a documented smoking policy, posted non-smoking signs, and metal receptacles, serving the entire component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, revealed the facility was unable to present a written smoking policy. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the smoking policy was not available for review. 2. Observation and interview on April 16, 2025, between 11:15 AM and 1:45 PM, revealed the facility lacked posted no smoking signs, in any room, ward or compartment, where flammable	K 0741		

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K 0741 SS=F	Continued from page 14 liquids, combustible gases or oxygen is used or stored. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the facility failed to post no smoking signs. 3. Observation and interview on April 16, 2025, at 12:05 PM, revealed the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied, and fire-resistant ashtrays, behind the facility at the picnic table area, where an abundance of cigarette butts were discarded on the ground. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the facility failed to provide required receptacles to be available to all areas where smoking is permitted.	K 0741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025	
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640702		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0761 SS=C	<p>NFPA 101 Maintenance, Inspection & Testing - Doors</p> <p>Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0761	<p>1 and 2. Maintenance Director has completed the annual fire door inspection in six of six smoke compartments.</p> <p>3. Maintenance department will be educated on the standards of the facility's annual fire door inspection.</p> <p>4. Maintenance or facility designee will audit facilities annual fire door inspection in life safety binder weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.</p>	<p>Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 640702				
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K 0761 SS=C	Continued from page 16 Based on document review and interview, it was determined the facility failed to provide documentation of the annual fire door inspection, in six of six smoke compartments within the component. Findings include: 1. Review of documentation on April 16, 2025, between 9:00 AM and 11:15 AM, revealed the facility could not provide documentation of the annual fire-rated door inspection. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the facility could not provide documentation of the annual fire door inspection.	K 0761		
K 0912 SS=E		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
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K 0912 SS=E	Continued from page 17 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	1 and 2. Maintenance Director has updated GFI's in D hall nurses station nourishment room (1 outlet), B hall beauty shop (3 outlets), and main kitchen prep area (2 outlets). 3. Maintenance department will be educated on the standards of maintaining power receptacles to be GFI within six feet of a water source. 4. Maintenance or facility designee will audit facilities GFI receptacles weekly x2 for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025	
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640702		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
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K 0912 SS=E	Continued from page 18 Based on observation and interview, it was determined the facility failed to maintain power receptacles to be Ground Fault Interruption (GFI) protected, within six feet of a water source, in three of six smoke zones within the component. Findings include: 1. Observation on April 16, 2025, between 12:30 PM and 12:45 PM, revealed various outlets were not GFI protected, but were within six feet of a water source, at the following locations: a. 12:30 PM, D Hall, Nurses' Station, Nourishment Area, 1 outlet; b. 12:40 PM, B Hall, Beauty Shop, by sinks, 3 outlets; c. 12:45 PM, Main Kitchen, Prep Area, by coffee machine and ice machine, 2 outlets. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed	K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
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K 0912 SS=E	Continued from page 19 the outlets were not GFI protected.	K 0912		
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the	K 0918	1 and 2. 4 hour building load test performed 3/8/2024 by GenServ. Maintenance Director has performed the monthly 30 min. test and will complete the annual 90 minute load bank inspection and testing of the facilities generator. 3. Maintenance department will be educated on the standards of completing weekly, monthly and annual inspections and testing of generator. 4. Maintenance or facility designee will audit facilities generator weekly for 2 months then quarterly throughout the year and results of the audit will be reported to the QA Committee.	Completion Date: 06/06/2025 Status: APPROVED Date: 04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025	
NAME OF PROVIDER OR SUPPLIER: CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 640702		STREET ADDRESS, CITY, STATE, ZIP CODE: 1070 STOUFFER AVENUE CHAMBERSBURG, PA 17201		
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K 0918 SS=F	Continued from page 20 emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395348	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025	
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K 0918 SS=F	Continued from page 21 Based on document review and interview, it was determined the facility failed to perform monthly and annual inspections and testing, required for the Essential Electrical System, which serves the entire component. Findings include: 1. Review of documentation and interview on April 16, 2025, between 10:25 AM and 10:28 AM, revealed the facility failed to perform weekly, monthly and annual inspections and testing of the generator, including the following: a. 10:25 AM, monthly, 30-minute load, using the transfer switches; b. 10:28 AM, annual, 90-minute load bank. Interview at the time of the exit conference with the Assistant Director of Nursing and Maintenance Director on April 16, 2025, at 1:45 PM, confirmed the facility failed to perform required maintenance	K 0918		

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K 0918 SS=F	Continued from page 22 and testing.	K 0918			



Certified End Page

CHAMBERSBURG SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 640702

SURVEY EXIT DATE: 04/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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