STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395647	A. BLDG: 00 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPIRITRUST LUTHERAN THE VILLAGE AT GETTYSBURG STATE LICENSE NUMBER: **124402**	**1075 OLD HARRISBURG ROAD GETTYSBURG, PA 17325**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights survey, which ended on April 30, 2026, it was determined that Spiritrust Lutheran The Village at Gettysburg was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, and Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0578 SS=D		F 0578		

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.

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. Order for resident #39 transcribed and placed in electronic medical record. 2. Advanced Directive orders audited for current residents to ensure electronic records reflect POLST/Advanced Directive. 3. Educate licensed nursing staff on the process of transcribing POLST/Advance Directive's at time of admission. 4. Audit all new admission X1 month for transcription of POLST/Advance Directive orders correctly listed on electronic chart, then 5 random admissions X2 months. All audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 3 Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the resident right to formulate an advanced directive for one of 12 residents reviewed (Resident 39). Findings include: Review of facility policy, titled "Advance Care Planning Standard" last reviewed March 23, 2026, read, in part, "Purpose: To assist each resident to exercise his/her right to make knowledgeable choices about care and treatment or to decline treatment. Incorporate the residents' choices into the medical record and orders related to treatment, care and services." Review of Resident 39's clinical record revealed diagnoses that included presence of right artificial knee joint, encounter for orthopedic aftercare, and muscle weakness. Review of Resident 39's clinical record failed to	F 0578		

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F 0578 SS=D	Continued from page 4 reveal a physician order or a care plan for her code status (a medical designation that indicates what life saving treatments a patient would or would not want if their heart or breathing stops). Review of Resident 39's hard paper medical chart on April 28, 2026, at 12:56 PM, failed to reveal a POLST form (Physician Orders for Life Sustaining Treatment- a medical order that allows seriously ill or frail individuals to specify the types of medical treatment they want during emergencies). During an interview with Employee 3 (Registered Nurse) on April 28, 2026, at 12:58 PM, the surveyor asked if Employee 3 could find Resident 39's code status in her electronic or paper medical record. Employee 3 stated it is usually in the physicians orders and under additional instructions in the electronic chart, and she was unsure of why she didn't have a POLST in her paper chart for reference. Employee 3 couldn't find it after one minute and stated she would not wait any longer to search at that point, and if Resident 39 started to	F 0578		

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F 0578 SS=D	Continued from page 5 code (a life threatening medical emergency requiring immediate resuscitation efforts), she would treat her as a full code and start performing CPR (Cardiopulmonary Resuscitation, an emergency procedure used to maintain blood flow and oxygen to vital organs when the heart stops beating). During an interview with Employee 8 (Licensed Practical Nurse) on April 28, 2026, at 1:03 PM, she revealed if she could not find a resident's code status in their electronic or paper medical record, she would start CPR and treat them as a full code. During an interview with Resident 39 on April 28, 2026, at 1:06 PM, she revealed Employee 9 went over advance directive information with her when she was admitted to the facility, and that her wishes are for DNR (Do Not Resuscitate- a medical order indicating that a person does not want CPR or other life-saving measures if their heart or breathing stops). Review of Resident 39's clinical record revealed a	F 0578		

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F 0578 SS=D	Continued from page 6 note written by Employee 9 (Social Worker) on April 14, 2026, that stated "POLST form reviewed, continues to decline to complete POLST but does request DNR code status." Interview with the Director of Nursing on April 30, 2026, at 11:11 AM, she revealed Resident 39's DNR code status order was missed from the batch physician orders and failed to be transcribed to the electronic chart orders. She stated that she would expect the order would have been put in electronically to be easily found by nursing staff in the event of a life threatening emergency. 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.5 (f)(i) Medical Records	F 0578		
F 0658 SS=D		F 0658		

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F 0658 SS=D	Continued from page 7 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	1. Facility cannot correct late administration of IV medication administration for resident identifier #39 during survey. Dr. was notified with no new orders for resident #39. 2. Audit completed, no other residents currently ordered IV medication 3. Education to licensed staff on IV medication administration to include timely administration and proper documentation. 4. Audit of all residents ordered an IV medication will be audited 3 times a week on random administration times for 1 month and then 2 times a week on all residents ordered IV medications for 1 month and then move audit to 1X a week on all residents ordered IV medication for 1 month. Audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

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F 0658 SS=D	Continued from page 8 Based on facility policy review, observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that services provided meet professional standards of practice for one of 12 residents reviewed (Resident 39). Findings include: Review of facility policy, titled "Medication Administration" last reviewed March 23, 2026, read, in part, "Purpose: Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. All medications are to be given in accordance with the 5 rights of medication administration: Right Time- Medications are administered within the time frame specified by the physician order." Review of Resident 39's clinical record revealed diagnoses that included presence of right artificial	F 0658		

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F 0658 SS=D	Continued from page 9 knee joint and muscle weakness. Review of Resident 39's physician orders revealed an order for "Ampicillin Sodium Intravenous (IV) Solution Reconstituted 2 gram, use 2000 milligram intravenously every 6 hours for cellulitis (infection)," with a start date of April 15, 2026. Review of Resident 39's MAR (Medication Administration Record - record of medications and treatments administered) revealed she is to get the Ampicillin IV medication at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM, daily. Review of Resident 39's care plan revealed a care plan focus area, "I am at risk of complications as I have IV therapy for infection," with an intervention for "IV therapy as ordered," initiated on April 14, 2026. Observation and resident interview in Resident 39's room on April 28, 2026, at 12:28 PM, revealed she had not yet received her IV medication to be	F 0658		

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F 0658 SS=D	Continued from page 10 administered at 12:00 PM and she was not sure why. Additional surveyor observation on April 28, 2026, at 1:13 PM, revealed the IV antibiotic had yet to be administered for the noon dose. During an interview with the Director of Nursing (DON) on April 29, 2026, at 1:45 PM, the surveyor revealed the concern with the late IV administration on April 28, 2026. Review of Resident 39's clinical record revealed a nursing progress note from April 29, 2026, at 2:58 PM, that read, "IV Ampicillin due 1200 on 4/28/26 given pass admin time and marked late on MAR. Med given at 1320 and marked on MAR at 1350. No signs or symptoms of infection noted. Incision to right knee well approximated, no drainage or redness noted. [Physician] aware with no new orders. Husband and resident both aware and voice no concerns over time that dose was given."	F 0658		

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F 0658 SS=D	Continued from page 11 Review of Resident 39's April MAR report revealed Resident 39's ampicillin dose was marked as given late on two other occasions. For the 12:00 AM dose on April 27, 2026, it was noted to be documented as administered at 2:20 AM; for the 12:00 AM dose on April 30, 2026, it was noted to be documented as administered at 1:56 AM. Interview with the DON on April 30, 3036, at 12:31 PM, revealed nurses can start the administration of a medication but get tasked with other priorities such as ADL care/toileting for the resident or an emergent situation that would require attention, and sign as completed at a later time. If those situations occur, a progress note should be put into the record as to why the medication was administered late or signed late but given on time. She further revealed her expectation that medications are administered timely and as ordered. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0658		

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F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Resident no longer resides in facility. 2. Staff member performing dressing change educated on performing wound care/clean dressing change following surveyor identifying the concern. 3. Education provided to licensed nursing staff on wound care/clean dressing change. 4. Audit of wound care involving dressing changes by licensed nursing staff will be completed on random shifts weekly for 2 residents X1 month, then 1 resident per week X 1 month and then biweekly of 1 resident X 1month. Audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

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F 0686 SS=D	Continued from page 13 Based on observation, staff interview, facility policy review, and clinical record review, it was determined that the facility failed to ensure that a resident receiving wound care was consistent with infection control standards of practice when placing medication in the base of a wound for one of 12 residents reviewed (Resident 7). Findings include: Review of the facility policy, titled "Dressing Change, Clean" last reviewed March 23, 2026, states the following steps: 1. Place plastic bag near foot of bed to receive soiled dressing. 2. Create clean field with paper towels or towelette drape. 3. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound. 4. Open dressing pack. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard it in plastic	F 0686		

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F 0686 SS=D	Continued from page 14 bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. 9. Pour prescribed solution onto gauze to be used for cleaning, if required. 10. Cleanse wound with prescribed solution. 11. Apply prescribed medication if ordered. 12. Apply dressings and secure with tape. 13. Remove gloves and discard with all unused supplies in plastic bag. A review of the clinical record for Resident 7 on April 30, 2026, revealed clinical diagnoses that included unstageable sacral pressure ulcer (a wound where the true depth cannot be determined because it is covered by slough) and hospice status (end of life). A review of Resident 7's physician orders dated April 2026, included an order for sacral wound care to be completed daily and as needed if dislodged or soiled. The wound care orders specify to cleanse the area with normal saline solution, pack with	F 0686		

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F 0686 SS=D	Continued from page 15 calcium alginate silver, and cover with a border foam dressing. Observation of wound care on Resident 7 on April 30, 2026, at 9:45 AM, revealed Employee 6 (Licensed Practical Nurse) used her clean gloved hand to remove a pen marker from under her PPE gown, then lifted the cuff of her scrub jacket to check the time, labeled the border foam dressing, then used the same gloved hand to pick up the calcium alginate silver and place it into the wound bed. During an interview with the Nursing Home Administrator (NHA) on April 30, 2026, at 11:31 AM, the NHA agreed that policy should be followed for dressing changes. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395647	A. BLDG: __00_____ B. WING: _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPIRITRUST LUTHERAN THE VILLAGE AT GETTYSBURG	**1075 OLD HARRISBURG ROAD GETTYSBURG, PA 17325**
STATE LICENSE NUMBER: **124402**	

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F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 17 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Removed, replaced and dated oxygen tubing for resident identifier # 5. Nebulizer mask for resident identifier # 37replaced and placed in bag with date for storage when not in use. 2. Audit done to ensure that the oxygen tubing was dated properly and residents oxygen and nebulizer equipment was being stored correctly when not in use. Audit included order was in place on mar/tar for nursing staff to document completion of dating and changing. 3. Education provided to licensed staff on process for changing oxygen tubing and dating tubing correctly. Education on cleaning nebulizer equipment and storing oxygen and nebulizer equipment when not being used provider. 4. Audit of oxygen tubing dates and storage of equipment involving oxygen tubing and nebulizer will be done weekly X 1 month on 5 residents, biweekly for 1 month on 5	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 18	F 0695	residents and then 5 audits X1 month. Audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 19 Based on policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to provide respiratory care and services consistent with professional standards of practicefor two of 12 residents reviewed for respiratory care (Resident 5 and 37). Findings include: Review of the facility policies revealed that they did not have a policy that specifically spoke about supplemental oxygen use or use of a nebulizer. Review of Resident 5's clinical record revealed diagnoses that included Asthma (a chronic, non-curable lung disease causing airway inflammation and muscle tightening) and obstructive sleep apnea (serious, common sleep disorder where throat muscles relax excessively, causing repeated airway collapse and breathing pauses [apnea] during sleep).	F 0695		

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F 0695 SS=D	Continued from page 20 Observation of Resident 5 on April 27, 2026, at 10:56 AM, revealed Resident 5 lying in bed. Resident 5 was wearing a nasal canula (oxygen delivery device) and receiving supplemental oxygen at 3 liters per minute and the oxygen tubing was not dated. Observation of Resident 5 on April 29, 2026, at 11:46 AM, revealed Resident 5 lying in bed. Resident 5 was wearing a nasal canula (oxygen delivery device) and receiving supplemental oxygen at 3 liters per minute and the oxygen tubing was not dated. Review of Resident 5's care plan revealed a care plan of: I have potential complications as I have asthma and restrictive lung disease, and an intervention of: give oxygen therapy as ordered, with a date initiated on June 17, 2016. Review of current physician orders for Resident 5 revealed an order for oxygen via nasal canula at 2-4 liters per minute, starting December 4, 2025.	F 0695		

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F 0695 SS=D	Continued from page 21 Interview with the Director of Nursing (DON) on April 29, 2026, at 1:15 PM, revealed that Resident 5's oxygen tubing should have been dated when it was applied or changed. Further interview revealed that the facility did not have a policy regarding supplemental oxygen use. Review of Resident 37's clinical record revealed diagnoses that included heart failure (a chronic, progressive condition where the heart cannot pump blood efficiently, leading to fatigue, shortness of breath, and fluid buildup) and muscle weakness (weakness in the muscles not explained by any medical diagnosis). Observation of Resident 37 on April 27, 2026, at 12:56 PM, revealed Resident 37 sitting in her recliner. On the table beside her, her nebulizer mask was sitting out on the table not covered or in a bag. Observation of Resident 37 on April 29, 2026, at 10:46 AM, revealed Resident 37 sitting in her	F 0695		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0695 SS=D	Continued from page 22 recliner. On the table beside her, her nebulizer mask was sitting out on the table not covered or in a bag. Review of Resident 37's care plan revealed a care plan with the focus area of, I have difficulty breathing due to CHF (congestive heart failure), with a revision date of January 11, 2025. Review of Resident 37's physician orders revealed an order for albuterol sulfate solution given via nebulizer daily at bedtime, with a start date of March 23, 2026. Interview with the DON on April 29, 2026, at 2:15 PM, revealed that she would expect the resident's mask to be cleaned and put away after use. Further interview revealed that the facility did not have a policy regarding nebulizer use. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		

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F 0803 SS=D	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	1. Facility cannot correct the inaccurate portion size served to the 5 residents observed during meal service during survey. Residents able to request additional serving of meal following original meal provided. 2. Appropriate portion sizes were provided to remaining residents moving forward following observation of the 5 residents during survey. 3. Education provided to cooks on following recipes and serving appropriate portion sizes. 4. Audit of random meal service will be completed daily for 2 weeks, then 3 times a week for 2 months. Audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

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F 0803 SS=D	Continued from page 24 Based on facility policy review, review of facility menu extension sheets, review of select facility recipe, observations, and staff interviews, it was determined that the facility failed to follow the diet extension sheets to provide a menu to meet the needs and preferences of residents for five of 47 residents reviewed with similar diet needs (Residents 6, 21, 28, 29, and 35). Findings include: Review of facility policy, titled "Recipes" last reviewed March 23, 2026, read, in part, "Recipes will be used in preparation of all menu items. To ensure proper nutritional adequacy, portion control, and cost of the menu item being prepared. Recipes are to be adjusted for facility yield and must be followed exactly." Review of facility policy, titled "Production Sheet" last reviewed March 23, 2026, read, in part, "A production sheet is developed for each meal based on the menu cycle. To ensure that the production	F 0803		

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F 0803 SS=D	Continued from page 25 team prepares menu items in the correct quantity and adheres to company standards of food quality. There is a production sheet for each meal. Included on this sheet are: All items to be prepared for that meal, their recipe number, and portion size. Quantity to be produced based on resident diet census form for all items listed." Review of facility menu extension sheets revealed the main meal served on Wednesday April 29, 2026, was to consist of two Baked Manicotti with tomato sauce (6 ounces- unit of measure), 4-ounces of Vegetable Blend, a 2-ounce Warm Dinner Roll with Butter, and one slice of Pound Cake with Fruit Topping. Observation during tray line meal service on April 29, 2026, 11:45 AM, revealed Residents 6, 21, 28, 29, and 35 were served only one manicotti. Observation of their meal tray tickets revealed they should have been served two.	F 0803		

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F 0803 SS=D	Continued from page 26 On April 29, 2026, at 11:56 AM, Employee 2 (Dietary Employee) paused the tray line meal service to make more fish flounder for the alternate menu and asked how the meal service was going. The surveyor revealed the concern with only one manicotti being served instead of two. Employee 2 then stated the manicotti were pretty big so he only gave one as they were at least three ounces. Review of facility recipe for the manicotti on April 29, 2026, at 11:59 AM, revealed one portion size of the manicotti was 6 ounces. During an interview with Employee 1 (Director of Dining Services) on April 29, 2026, at 12:17 PM, revealed he weighed one manicotti from the pan on the steam table and it weighed approximately 5 ounces, but he was in agreement that it was the incorrect portion size. Interview with the Nursing Home Administrator on April 29, 2026, at 12:17 PM, she revealed she would expect recipes to be followed and	F 0803		

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F 0803 SS=D	Continued from page 27 appropriate portions to be served during meal service. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0803		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible	F 0880	1. Glucometers were cleaned per manufacturer's instructions following observation during state survey 2. Ensured proper disinfectant wipes used for cleaning glucometers were available in nursing carts. 3. Education provided to licensed nursing staff on cleaning and disinfecting the glucometers after use. 4. Audit to be completed of proper glucometer cleaning during medication pass 3 times a week on random shifts x 1 month, 2 times a week for 1 month and then 1 time a week X 1 month. Audits will be taken to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

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F 0880 SS=D	Continued from page 28 communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 0880		

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F 0880 SS=D	Continued from page 29 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 30 Based on observation, product label, policy review, and staff interviews, it was determined that the facility failed to maintain a safe environment that supports infection prevention and control for glucometer cleaning for two of three nursing units reviewed. Findings include: A review of the facility policy, titled "Glucometer: Accountability of Medical Equipment Standard," last reviewed March 23, 2026, states, "The glucometer shall be cleaned per manufacturer's instructions before use, after use, and when stored." A review of the manufacturer's instructions for cleaning and disinfecting the specific brand of glucometer that the facility used recommends an EPA (Environmental Protection Agency)- registered disinfectant wipe (such as bleach wipes) to clean all external surfaces, including the front, back and sides, ensuring the disinfectant stays wet on the	F 0880		

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F 0880 SS=D	Continued from page 31 surface for the required contact time, typically about 4 minutes. During an interview with Employee 3 (Licensed Practical Nurse), the Employee was asked to review her process during use of the glucometer on a resident. Employee 3 demonstrated cleaning the glucometer after use with alcohol wipes and placing it on the medication cart to air dry prior to storing it back in the medication cart. The Employee pulled a container of bleach wipes (EPA recommended disinfectant) from the medication cart and stated, "I probably should use these, but I'm old school and prefer alcohol wipes." During an interview with Employee 4 (Licensed Practical Nurse), the Employee was asked to review her process during use of the glucometer on a resident. Employee 4 stated the following, "After use, I wipe the glucometer down with alcohol wipes, and lay it down to air dry, then store it in the medication cart."	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395647	A. BLDG: __00_____ B. WING: _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SPIRITRUST LUTHERAN THE VILLAGE AT GETTYSBURG STATE LICENSE NUMBER: **124402**	**1075 OLD HARRISBURG ROAD GETTYSBURG, PA 17325**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0880 SS=D	Continued from page 32 During an interview with the Nursing Home Administrator (NHA) on April 30, 2026, at 11:30 AM, the NHA was asked if she expected staff to disinfect the glucometer per manufacturer's recommendations. The NHA replied, "I expect staff to follow the policy." 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0880		

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P 1700	Prevention, control and surveillance of tuber (b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. This REGULATION is not met as evidenced by:	P 1700	1. Employee screenings were corrected to follow current policy for TB testing at time of employment for staff identifier # 9 and #10. 2. Audit of employee files that were hired in the past 3 months completed to ensure current policy for TB testing/screening and CDC guidelines was followed, at time of employment. 3. Education provided to Human Resource Manager on current TB policy and current CDC guidelines for testing/screening of staff at time of employment. 4. Audit of all new hires TB records will be completed X3 months. Audits will be brought to QAPI for further recommendations for quality assurance and performance improvement.	Completion Date: **06/17/2026** Status: **APPROVED** Date: **05/14/2026**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1700	Continued from page 1 Based on facility policy review, personnel file review, and staff interviews, it was determined the facility failed to follow policy to test for Tuberculosis (TB-a contagious infection caused by Mycobacterium tuberculosis, primarily affecting the lungs) for two of five employees reviewed (Employees 9 and 10). Findings include: Review of facility policy, titled "Respiratory Protection Program Standard," last reviewed March 23, 2026, stated, "A baseline TB status shall be obtained on all residents and team members/volunteers in the center. The 2-step intradermal tuberculin skin test shall be the method used for initial testing of residents and team members. If the applicant provides documentation of a two-step (TST) within the past 12 months prior testing may stand as the initial TST. If more than twelve (12) months have passed since prior two-step TB test, but a one-step has been given in the last 12 months, a one-step test will be given to	P 1700		

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P 1700	Continued from page 2 full-fill 2 step requirement." Review of Employee 9's personnel file revealed a hire date of April 20, 2026. Employee 9's personnel file included results of a 1-step TST dated December 17, 2025, and the personnel file failed to include any other TB testing at time of hire. Review of Employee 10's personnel file revealed that her hire date was January 27, 2026. Her personnel file included results of a QuantiFERON Gold (a highly accurate, single visit tuberculosis blood test) dated January 27, 2025, (a year prior to her hire date), which was negative. Her personnel file failed to include any other TB testing at time of hire. During staff interview with Employee 11 (Human Resources Manager) on April 29, 2026, at 9:00 AM, confirmed that she was following facility protocol for accepting test results from outside the facility within the last year for new hires without further testing	P 1700		

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P 1700	Continued from page 3 During an interview with the Nursing Home Administrator (NHA) and Director of Nursing on April 30, 2026, at 11:31 AM, the NHA indicated that she would expect the facility to follow their current policy for TB testing at time of employment and follow current CDC recommendations.	P 1700		

Certified End Page

SPIRITRUST LUTHERAN THE VILLAGE AT GETTYSBURG

STATE LICENSE NUMBER: 124402

SURVEY EXIT DATE: 04/30/2026

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
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