



Certified End Page

GETTYSBURG CENTER

STATE LICENSE NUMBER: 078502

SURVEY EXIT DATE: 02/04/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502	STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325
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K 0000	INITIAL COMMENT Facility ID #078502 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on February 4, 2025, it was determined that Gettysburg 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 II (222), fire resistive structure, without a basement, which is fully sprinklered.	K 0000		
K 0100 SS=F		K 0100		

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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K 0100 SS=F	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	Facility drawings will include resident room capacities, door swing designation and space/room designators. Annual testing and inspection of installed carbon monoxide alarms will be completed. Carbon monoxide alarms will be placed where on-duty staff can hear the alarms 2. Facility staff will be educated on carbon monoxide alarms. Maintenance staff will be educated on the facility drawing. 3. One carbon monoxide test will be completed monthly for 2 months. Audit results will be reviewed at the next QAPI meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

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K 0100 SS=F	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on document review and interview, it was	K 0100		

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K 0100 SS=F	Continued from page 3 determined the facility failed to meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Review of documentation and interview on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility life safety drawings lacked resident room capacities, door swing designation, space/room designators and all rated assemblies highlighted. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the life safety drawings did not depict all required information. 2. Review of documentation and interview on February 4, 2025, between 9:30 AM and 11:15	K 0100		

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K 0100 SS=F	Continued from page 4 AM, revealed the facility lacked documentation of annual testing and inspection of installed Carbon Monoxide Alarms, per manufacture's instructions, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the lack of documentation annual inspections were not done. 3. Review of documentation and interview on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility could not verify the installed carbon monoxide alarms could be heard by on-duty staff, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the facility could not verify carbon monoxide detectors could be heard by on-duty staff.	K 0100		

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K 0100 SS=F	Continued from page 5 4. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility lacked documentation, verifying evacuation and alarm protocols, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the lack of documentation of evacuation and alarm protocols.	K 0100		
K 0291 SS=E		K 0291		

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K 0291 SS=E	Continued from page 6 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	Annual testing and monthly testing of battery powered emergency lighting will occur. Maintenance mechanical room battery will be replaced. Annual lighting check will occur by 3/15/25. 2. Maintenance staff will be educated on completing monthly and annual testing of battery powered emergency lighting. 3. A quarterly audit will occur to ensure that monthly testing of battery powered emergency lighting is occurring. Audit results will be reported at the next QAPI meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

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K 0291 SS=E	Continued from page 7 Based on document review, observation and interview, it was determined the facility lacked documentation, verifying the maintenance of battery-powered emergency lighting sources, and failed to maintain emergency lighting fixtures, affecting the entire component. Findings include: 1. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, it was revealed the facility failed to perform functional monthly and annual testing of battery powered emergency lighting sources. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the facility failed to perform installed back-up emergency lighting testing. 2. Observation on February 4, 2025, at 11:55 AM, revealed the Maintenance Mechanical Room battery	K 0291		

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K 0291 SS=E	Continued from page 8 back-up lighting unit failed to operate. Interview with the Acting Administrator and Director of Maintenance on February 4, 2025, at 2:00 PM, confirmed the battery back-up light failed to operate.	K 0291		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 10 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors, to self-close and positively latch, affecting two of six smoke zones within the component. Findings include: 1. Observation on February 4, 2025, at 12:15 PM, revealed the "Dock Area" right leaf failed to self-close, due to lack of self-closing device. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the door failed to self-close. 2. Observation on February 4, 2025, at 12:20 PM, revealed the Kitchen Storage door failed to positively latch, due to lack of lock cylinder. Interview at the time of the exit conference with the	K 0321		

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K 0321 SS=E	Continued from page 12 Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the door failed to positively latch.	K 0321		
K 0324 SS=C	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	Quick checks will be completed monthly on the kitchen suppression system. Going forward the kitchen exhaust ductwork will be cleaned semiannually. 2. Quick checks will be completed monthly and the kitchen exhaust ductwork will be clean semi-annually going forward. 3. Maintenance staff will be educated on completing monthly quick checks on the kitchen suppression system and having exhaust ductwork cleaned semiannually. 4. Audits will be completed semi annually regarding the kitchen suppression system and exhaust ductwork. Audit results will be reported to QAPI.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

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K 0324 SS=C	Continued from page 13 Based on document review and interview, it was determined the facility failed to document the owner's quick checks on the building's Kitchen Suppression System, and failed to provide documentation of semiannual exhaust ductwork cleaning, affecting one of six smoke zones within the component. Findings include: 1. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility lacked documentation of monthly "quick checks" being performed, on the Kitchen Suppression System. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not provide documentation of monthly checks performed. 2. Review of documentation on February 4, 2025,	K 0324		

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K 0324 SS=C	Continued from page 14 between 9:30 AM and 11:15 AM, revealed the facility lacked documentation, verifying the Kitchen exhaust ductwork had been cleaned, semiannually, within the past year. Facility could only provide documentation from October 10, 2024. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not provide Kitchen ductwork documentation, for one full year.	K 0324		
K 0345 SS=C	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	Annual inspection completed on March 15, 2024. Fire alarm system will be inspected annually going forward. 3. Maintenance staff will be educated on having the fire alarm system inspected annually. 4. Fire alarm system audit will be completed semi annually to be sure that the fire inspections are occurring and results reported at the next QAPI meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

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K 0345 SS=C	Continued from page 15 Based on document review and interview, it was determined the facility failed to provide documentation, verifying the 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 February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility failed to provide documentation, verifying 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 Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility failed to provide documentation, verifying annual testing and inspection of the fire alarm system had occurred, within the previous twelve months.	K 0345		

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K 0353 SS=F	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>The facility will have a sprinkler inspection completed on 3/4/25. The maintenance staff will be educated on completing a sprinkler inspection annually. 3. A quarterly audit will be completed to ensure a sprinkler inspection was completed. Audits results will be reported to the next QAPI meeting.</p>	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/04/2025</p>

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K 0353 SS=F	Continued from page 17 Based on document review and interview, it was determined the facility failed to perform annual and tri-annual sprinkler maintenance and testing, affecting the entire component. Findings include: 1. Review of documentation on February 4, 2025, between 9:50 AM and 9:53 AM, revealed the facility lacked documentation, for the following: a. 9:50 AM. wet system, annual, main drain and control valves; b. 9:53 AM, dry system, annual trip test and 3-year, full flow trip test. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed inspections were not performed.	K 0353		
K 0355 SS=C		K 0355		

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NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502		STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325		
(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 0355 SS=C	Continued from page 18 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	Visual inspections of fire extinguishers will be completed monthly. An annual fire extinguisher inspection will be completed. 2. Maintenance staff will be educated on completing visual inspections monthly on fire extinguishers and having an annual inspection completed on fire extinguishers. 3. A monthly audit will be completed to ensure visual inspections of fire extinguishers are occurring and an annual fire extinguisher inspection was completed. Audit results will be reported at the next QAPI meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502		STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325		
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K 0355 SS=C	Continued from page 19 Based on document review and interview, it was determined the facility failed to verify monthly and annual inspections of portable fire extinguishers, affecting the entire component. Findings include: 1. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility lacked documentation, verifying the fire extinguishers throughout the component had been subjected to monthly visual inspections. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not provide documentation of monthly inspections. 2. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility lacked documentation, verifying the annual	K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502		STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325		
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K 0355 SS=C	Continued from page 20 fire extinguisher inspection had been performed. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not provide documentation of the annual inspection.	K 0355		
K 0712 SS=C	NFPA 101 Fire Drills 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 This REQUIREMENT is not met as evidenced by:	K 0712	Fire drills will be performed, one per shift, per quarter. 2. Maintenance staff will be educated on completing fire drills on one shift per quarter. 3. An audit will occur quarterly to ensure fire drills will be performed one per shift, per quarter. Audit results will be reported to QAPI.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0712 SS=C	Continued from page 21 Based on document review and interview, it was determined the facility failed to conduct and perform fire drills (one per shift, per quarter), affecting the entire component. Findings include: 1. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility did not perform fire drills, during the following: a. 2nd quarter 2024, 1st shift; b. 2nd quarter 2024, 2nd shift; c. 2nd quarter 2024, 3rd shift. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the fire drills were not performed.	K 0712		
K 0761 SS=C		K 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502		STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325		
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K 0761 SS=C	Continued from page 22 NFPA 101 Maintenance, Inspection & Testing - Doors 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) This REQUIREMENT is not met as evidenced by:	K 0761	Fire doors will be inspected annually. 2. Maintenance staff will be educated in completing an annual fire door inspection. 3. Fire doors will be audited semi-annually and the results of the audits will be reported to QAPI.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: GETTYSBURG CENTER STATE LICENSE NUMBER: 078502		STREET ADDRESS, CITY, STATE, ZIP CODE: 867 YORK ROAD GETTYSBURG, PA 17325		
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K 0761 SS=C	Continued from page 23 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 February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility documentation of the annual fire-rated door inspection did not include all the fire-rated doors in the facility. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not provide documentation of the annual fire door inspection for all fire doors.	K 0761		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
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K 0918 SS=F	Continued from page 24 NFPA 101 Electrical Systems - Essential Electric System 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 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	K 0918	Diesel fuel for the generator will be inspected. A 90-minute load bank test will be completed as well as a 4 hour load test. 2. Maintenance staff will be educated on the necessary inspections needed for the emergency generator. 3. A semi annual audit will be completed to ensure that the necessary tests for the emergency generator have occurred. Audit results will be reported to QAPI.	Completion Date: 03/24/2025 Status: APPROVED Date: 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0918 SS=F	Continued from page 25 (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: 395733	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
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K 0918 SS=F	Continued from page 26 Based on document review, observation and interview, it was determined the facility failed to provide diesel fuel quality testing, and required maintenance and testing of the emergency generator, which serves the entire component. Findings include: 1. Review of documentation on February 4, 2025, between 9:30 AM and 11:15 AM, revealed the facility failed to provide documentation, verifying the quality diesel fuel for the emergency generator had been inspected, within the previous twelve months. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not verify the quality of diesel fuel tested, in past twelve months. 2. Review of documentation and interview on February 4, 2025, between 10:20 AM and 10:23	K 0918		

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K 0918 SS=F	Continued from page 27 AM, revealed the facility lacked documentation, for the following: a. 10:20 AM, annual 90-minute load bank; b. 10:23 AM, 3-year, 4-hour load test. Interview at the time of the exit conference with the Administrator and Maintenance Director on February 4, 2025, at 2:00 PM, confirmed the facility could not verify emergency generator tests were performed.	K 0918			



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GETTYSBURG CENTER

STATE LICENSE NUMBER: 078502

SURVEY EXIT DATE: 02/04/2025

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