STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395918	A. BLDG: 00 B. WING:	04/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: **100902**	**55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201**

(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, Complaint, and Civil Rights survey which ended on April 3, 2025, it was determined that Transitions Healthcare Shook Home 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 0577 SS=E		F 0577		

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 0577 SS=E	Continued from page 1 483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 0577	Preparation and or evaluation of the following plan of correction set forth in this document does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law. 1. At time of discovery, the survey binder was updated to include the most recent surveys. 2. Education was provided by the Director of Operations to the Nursing Home administrator on updating the binder after a survey is cleared and the results are posted. 3. An audit will be conducted weekly x 4 by the NHA or designee to verify that any surveys within the prior week have been included in the	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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F 0577 SS=E	Continued from page 2	F 0577	public binder. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	

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F 0577 SS=E	Continued from page 3 Based on observation and staff interview, it was determined that the facility failed to post the most recent Federal or State survey results for one of one survey books observed (located in main entrance lobby). Findings Include: Observation of the survey binder located in the main entrance lobby on April 1, 2025, at 11:27 AM, revealed the most recent survey results present were dated August 2023. Review of the facility's survey history revealed the most recent survey result that could have been posted was conducted on March 19, 2025. During an interview with the Nursing Home Administrator on April 2, 2025, at 1:02 PM, he revealed the expectation that the survey books should be up to date and confirmed that they had been updated. 28 Pa. Code 201.14 Responsibility of licensee	F 0577		

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F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	1. The facility cannot retro entry of the PB-22 that was not submitted timely for R52. The resident was not assessed at the time of the event due to staff not reporting. 2. The facility has a new Director of Nursing and education provided by the regional nurse/designee on timely reporting of PB-22 submissions. An audit was completed, and no other residents were identified as having similar experience. 3. An audit will be conducted by the NHA/designee via line listing of reportable events weekly x 4 to ensure that any reportable requiring a PB-22 has timely submission of the documentation. All staff completed abuse training in March 2025 which included immediately reporting alleged violations. Abuse training is completed regularly - 2 times a year. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/10/2025**

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F 0609 SS=D	Continued from page 5 Based on review of facility policy, review of select facility documentation, and staff interview, it was determined that the facility failed to ensure all alleged violations involving abuse were reported immediately for one of two residents reviewed for abuse (Resident 52). Findings include: Review of facility policy, titled "Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property," revised June 14, 2023, revealed, "This facility's policy is to immediately report and investigate all allegations of mistreatment, neglect, abuse, misappropriation of a resident's property or any injury of unknown origin...Facility staff will be trained to report any oral or written reports of alleged neglect, abuse, mistreatment, and misappropriation of resident's property...Any report or suspicion of an incident is to be reported immediately to the charge nurse/supervisor...The Administrator and the Director of Nursing are to be notified immediately by the charge nurse/supervisor	F 0609		

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F 0609 SS=D	Continued from page 6 who receives the report. The Administrator or his designated person will notify the Licensing and Regulatory Agency (Department of Health/DHS), Protective Services, Local Police Department, and other state designated agencies as required." Review of Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property, revealed that on December 12, 2024, Resident 52 stated she wanted to attend a church activity, but Employee 3 (Nurse Aide) told her she was going to bed and not the activity. Further review of this form revealed that this incident was reported to Employee 2 (Registered Nurse) on December 13, 2024, who reported it to Employee 4 (Social Worker) on that date. It also stated that the investigation into this alleged incident of abuse did not start until December 16, 2024, and was not reported to the state regulatory agency until December 17, 2024. Review of Employee 2's witness statement (undated) revealed, "[Resident 52] reported to this writer on the afternoon of 12/13/24 she wanted to	F 0609		

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F 0609 SS=D	Continued from page 7 attend the evening activity after supper to listen to a group of Christmas carolers singing in the activity room. [Resident 52] said that a tall colored girl asked her 'where do you think you are going' when [Resident 52] was waiting to go down to the activity. [Resident 52] told the tall colored girl that she wanted to go to the activity to listen to Christmas carolers. [Resident 52] said that 'the tall colored girl then said no you're not doing that you are going to bed.' [Resident 52] was very upset and crying at the time when she shared this with this writer." Review of Employee 4's witness statement (undated) revealed, "Spoke to resident on 12/16 about incident on 12/12 (Thursday). Resident stated she was not allowed to go to activities to watch the Christmas carolers sing because she had to go to bed and it was 6 pm. She began to cry because she said she did not want to go to bed and was waiting for activities. I asked her who told her this she said her aide, she didn't know the name, only that it was a 'tall black girl.'"	F 0609		

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F 0609 SS=D	Continued from page 8 During an interview with the Director of Nursing (DON) on April 3, 2025, at 11:03 AM, she acknowledged that there was a delay in reporting the aforementioned allegation of abuse. She revealed that the incident took place on December 12, 2024. The Resident reported the incident to Employee 2 during a care plan meeting on December 13, 2024. Employee 2 passed it along to Employee 4 for follow-up, but Employee 4 was not working that day. Administration did not become aware of the incident until December 16, 2024. The DON also revealed that verbal education was provided to Employee 2 regarding required timeframes and process for reporting allegations of potential abuse/neglect. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0609		
F 0623 SS=E		F 0623		

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F 0623 SS=E	Continued from page 9 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The involuntary transfer notification form cannot be recreated for (Residents 47, 50, and 58) who received it. The involuntary transfer/discharge form has been updated to include the required elements. 2. The Director of Operations/designee has provided education to the NHA and DON on the correct formatting of this notification. An audit was completed for involuntary Transfer/Discharges starting March 1, 2025. Of these 12 involuntary transfers 3 remain in the hospital and will receive the corrected form listing the address and phone number of the entity which receives request for appeal along with PA State Long Term Care Ombudsman, Advocacy Agency for Intellectual or Developmental Disability and Advocacy Agency for Metal Disorder or Related Disability addresses and phone numbers.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/11/2025**

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F 0623 SS=E	Continued from page 10 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	3. An audit will be conducted weekly x 4 of involuntary transfer/discharge notifications to ensure that the proper form is used for these instances. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	

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F 0623 SS=E	Continued from page 11 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=E	Continued from page 12 Based on clinical record review, facility document review, and staff interviews, it was determined that the facility failed to provide a notice of transfer that included the required information for three of four resident records reviewed for hospitalizations (Residents 47, 50, and 58). Findings include: Review of Resident 47's clinical record revealed diagnoses that included atrial fibrillation (irregular and rapid heartbeats on the upper chamber of the heart) and acute kidney failure (a sudden and significant decrease in kidney function). Further review of Resident 47's clinical record revealed that she had been transferred and admitted to the hospital on February 23, 2025. Review of facility provided document, titled "Notice of Proposed Involuntary Discharge or Transfer", revealed the notice did not contain the location of transfer, statement of the Resident's appeal rights,	F 0623		

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F 0623 SS=E	Continued from page 13 the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the Nursing Home Administrator (NHA) on April 3, 2025, at 12:02 PM, the NHA confirmed that the facility transfer notice did not contain all the required information. Review of Resident 50's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), atrial fibrillation, and chronic respiratory failure with hypoxia (long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in	F 0623		

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F 0623 SS=E	Continued from page 14 the body). Review of Resident 50's clinical record revealed that she had been transferred and admitted to the hospital on October 11, 2024; November 13, 2024; and February 8, 2025. Review of facility provided document, titled "Notice of Proposed Involuntary Discharge or Transfer", revealed the notice did not contain the location of transfer, statement of the Resident's appeal rights, the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the NHA on April 3, 2025, at 12:02 PM, the NHA confirmed that the facility transfer notice did not contain all the required	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395918	A. BLDG: 00 B. WING:	04/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: **100902**	**55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201**

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F 0623 SS=E	Continued from page 15 information. Review of Resident 58's clinical record revealed diagnoses that included paroxysmal atrial fibrillation and acute kidney failure. Further review of Resident 58's clinical record revealed that he had been transferred and admitted to the hospital on February 6, 2025. Review of facility provided document, titled "Notice of Proposed Involuntary Discharge or Transfer", revealed the notice did not contain the location of transfer, statement of the Resident's appeal rights, the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders.	F 0623		

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 0623 SS=E	Continued from page 16 During a staff interview with the NHA on April 3, 2025, at 12:02 PM, the NHA confirmed that the facility transfer notice did not contain all the required information. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0623		
F 0656 SS=D		F 0656		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0656 SS=D	Continued from page 17 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. The Care plans identified for dementia (R24) and anticoagulation (R13) were updated upon discovery. 2. No other care plans were identified as not including a diagnosis or medication. Education was provided by the Regional Nurse/designee to the IDT team on ensuring Care plan accuracy with medications and diagnosis to their respective discipline. 3. An audit will be conducted by the RNAC or designee on care plans on 5 patients per week x 2 weeks then 5 patients monthly x 2 months for patients with a dementia diagnosis or on anticoagulation treatment. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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 0656 SS=D	Continued from page 18 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 19 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for two of 17 residents reviewed (Residents 13 and 24). Findings include: Review of facility policy, titled "Care Plan - Comprehensive," last reviewed December 2024, revealed, "Each resident will have a comprehensive care plan developed that is individualized, included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident, and reflect the resident's cultural references, values, and practices." Review of Resident 13's clinical record revealed diagnoses that included atrial fibrillation (upper chambers of the heartbeat irregularly and rapidly) and heart failure (the heart cannot pump effectively enough to meet the body's needs).	F 0656		

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F 0656 SS=D	Continued from page 20 Review of Resident 13's physician orders revealed an order for Apixaban (anticoagulant medication) 2.5 milligrams two times a day, with a start date of June 11, 2024. Review of Resident 13's comprehensive care plan failed to reveal any care planning for Resident 13's anticoagulant medication use or side effect monitoring. During a staff interview on April 3, 2025 at 11:09 AM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the NHA stated Resident 13's care plan had been updated and it was the expectation of the facility that comprehensive care plans be developed accurately. Review of Resident 24's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes	F 0656		

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F 0656 SS=D	Continued from page 21 obstructed airflow from the lungs). Further review of Resident 24's clinical record revealed she was admitted to the facility on March 20, 2025. Review of Resident 24's hospital discharge summary dated March 20, 2025, revealed that dementia associated with other underlying disease was noted as one of the problems addressed during her stay. Review of Resident 24's practitioner visit notes dated March 25, 2025, revealed that Resident 24 was discharged home from the facility in January 2025, but had been seen in the emergency room four times since then. Two of the visits were related to increased episodes of confusion, and her MoCA score (Montreal Cognitive Assessment - a highly sensitive tool for early detection of mild cognitive impairment) indicated "significant cognitive impairment." Further review revealed that when examined, Resident 24 confirmed she did have confusion and stated she was unsure where she was.	F 0656		

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F 0656 SS=D	Continued from page 22 Review of Resident 24's care plan failed to reveal any information related to her cognitive impairment or dementia diagnosis. During an interview with the NHA on April 3, 2025, at 11:02 AM, he revealed the expectation that Resident 24's cognitive impairment/dementia diagnosis should have been included in her plan of care. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0656		
F 0657 SS=D		F 0657		

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 0657 SS=D	Continued from page 23 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. The identified care plan was updated to reflect that patient R55 was not an active smoker and this was resolved. R 48 care plan was updated to include the use of Ted hose to control edema. 2. No other care plans were identified as needing updated secondary to a change in plan of care. Education was provided by the Regional Nurse/designee to the IDT team on ensuring Care plan accuracy with medications and diagnosis to their respective discipline 3. An audit will be conducted by the RNAC or designee on care plans for 5 patients per week x 2 weeks then 5 patients monthly x 2 months on patient care plans 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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F 0657 SS=D	Continued from page 24 Based on facility policy review, review of facility admission agreement, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the resident care plan was reviewed and revised to reflect the resident's current status for two of 21 residents reviewed (Residents 48 and 55). Findings include: Review of facility policy, titled "Care Plan - Comprehensive," revised September 28, 2022, revealed, "Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." Review of Resident 48's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to	F 0657		

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F 0657 SS=D	Continued from page 25 interfere with one's daily activities), and depression. Review of Resident 48's clinical record progress notes revealed a nurse's note dated March 17, 2025, at 1:52 PM, that indicated he had edema (swelling caused by too much fluid trapped in the body's tissues) in both of his lower legs. Review of Resident 48's physician orders revealed an order for TED stockings (compression stockings used to reduce chance of blood clots and to promote increased blood flow velocity in the legs), apply in AM and remove in PM, dated March 17, 2025. Review of Resident 48's care plan failed to reveal a focus for his edema or the use of TED hose. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 3, 2025, at 10:45 AM, the DON confirmed that Resident 48's care plan should have been updated to reflect his edema and the use of	F 0657		

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F 0657 SS=D	Continued from page 26 TED hose. Review of the facility admission agreement, effective July 27, 2015, revealed, "The facility does not permit smoking anywhere on its premises." Review of Resident 55's clinical record revealed diagnoses that included congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and other symptoms and signs involving cognitive functions and awareness. Review of Resident 55's care plan revealed a focus area of, "[Resident 55] wishes to be a smoker; smoking evaluation has determined resident's degree of independence for safe smoking", initiated February 20, 2025. Further review revealed an intervention to "inform and orient resident to smoking areas." Review of Resident 55's clinical record failed to reveal that she was an active smoker.	F 0657		

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F 0657 SS=D	Continued from page 27 During an interview with the NHA on April 1, 2025, at 9:43 AM, he confirmed that the facility was non-smoking. During an interview with the DON on April 3, 2025, at 11:10 AM, she revealed the expectation that smoking should have been removed from Resident 55's care plan. 42 CFR 483.21(b)(2) Comprehensive Care Plans 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0657		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 28 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. At time of discovery, the resident R51 code status was updated to reflect the wishes to be a DNR. 2. A whole house audit was completed upon discovery and all patients had correlating orders and POLSTS reflective of their wishes. 3. Education was provided by the Director of Nursing to Social services and licensed clinical staff to ensure that the POLST is reflective of any advanced directive orders. New admissions and any patient with a change in code status will be audited weekly x 4 to ensure proper code status is reflective in the order. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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 0684 SS=D	Continued from page 29 Based on clinical record review and staff interviews, it was determined that the facility failed to provide care and services in accordance with professional standards of practice to ensure each resident's highest level of well-being for one of three residents reviewed for advanced directives (Resident 51). Findings Include: Review of Resident 51's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking, and behavior) and type 2 diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel, resulting in too much sugar circulating in the bloodstream). Further review of Resident 51's clinical record revealed a POLST form (Pennsylvania Orders for Life Sustaining Treatment), dated December 23, 2024, stating that if Resident 51 was found with no pulse and not breathing, Resident 51 did not wish to	F 0684		

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F 0684 SS=D	Continued from page 30 be resuscitated. Review of Resident 51's physician orders revealed an order dated July 3, 2024, for Full Code, meaning resuscitation should be attempted if she was found without a pulse and not breathing. During an interview with the Nursing Home Administrator on April 3, 2025, at 10:59 AM, he confirmed that Resident 51's orders should have reflected her DNR (Do Not Resuscitate) status. He also revealed that a whole house audit was completed to ensure accuracy of code statuses. 28 Pa. Code 211.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0686 SS=D		F 0686		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: **100902**	**55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201**

(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 0686 SS=D	Continued from page 31 483.25(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. At time of discovery the nurse was provided education by the DON/NHA on enhanced barrier precautions. The facility cannot retro date the dressing change regardless that the MAR indicates the dressing had been changed the day prior. 2. All other dressings were appropriately dated, and all other enhanced barrier precautions were properly followed. Education was provided by the DON/Designee to the licensed clinical staff on the dating of completed treatments and enhanced barrier precautions. 3. An audit will be conducted for 5 patients per week x 2 weeks then 3 patients weekly for 2 months for patients with dressing changes and or enhanced barrier precautions 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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 0686 SS=D	Continued from page 32 Based on review of facility policy, record review, observation, and staff interview, it was determined that the facility failed ensure the resident received care, consistent with professional standards, to treat and prevent pressure ulcers for one of one resident reviewed (Resident 49). Findings Include: Review of facility policy, titled CLIN-046 Dressing Changes, Revised March 28, 2016, revealed in step 11. "Write the date, time, and initials on the dressing". Review of facility policy, titled IC- Enhanced Barrier Precautions, with a revision date of April 1, 2024, indicated that residents on enhanced barrier precautions require the use of gloves and a protective gown for high contact resident care activities, including wound care and any skin opening requiring a dressing. Review of Resident 49's clinical record revealed	F 0686		

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F 0686 SS=D	Continued from page 33 diagnoses that included pressure ulcer of right heel (localized area of damaged skin or tissue that occurs when pressure is applied to the skin for a prolonged period of time) and diabetes (a disease that effects how the body utilizes and regulates blood sugar). Review of Resident 49's current physician orders revealed an order to cleanse Resident 49's right heel with wound cleanser, apply medihoney (wound medication) and apply gauze to cover, with a start date of February 25, 2025. Another order revealed Resident 49 required enhanced barrier precautions related to her right heel, starting on February 11, 2025. Observation of Resident 49's dressing change to right heel on April 2, 2025, at 10:41 AM, revealed Employee 1(Registered Nurse) was completing Resident 49's right heel. When Employee 1 removed the dressing from Resident 49's heel, she confirmed that the dressing was not dated or timed, and she could not tell when it was applied. For the duration of the dressing change, Employee 1 was	F 0686		

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F 0686 SS=D	Continued from page 34 not wearing a gown at any time during the procedure. Interview with the Director of Nursing on April 3, 2025, at 12:51 PM, revealed that Resident 49's dressing should have been dated and Employee 1 should have followed the enhanced barrier precautions policy. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0686		
F 0692 SS=E		F 0692		

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 0692 SS=E	Continued from page 35 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. At time of discovery the fluid restriction batch orders were updated for R50 to be reflective of her specific restrictions and the distribution of those fluids from dietary and nursing. There were no negative outcomes identified 2. Education was provided to the nursing and dietary departments by the DON/designee on proper reading of the fluid restriction orders, dietary and nursing's role in maintaining these orders relative to the patient's plan of care. Audit completed of Residents on fluid restrictions and had their orders changed to be reflective of her specific restrictions and the distribution of those fluids from dietary and nursing. 3. An audit will be conducted for patients on fluid restrictions k x 2 weeks then monthly x 2 months to ensure that fluid restrictions are being properly administered per order	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/10/2025**

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 0692 SS=E	Continued from page 36	F 0692	4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	

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 0692 SS=E	Continued from page 37 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to monitor hydration to ensure proper hydration for one of two residents reviewed for hydration (Resident 50). Findings include: Review of facility policy, titled "CLIN-054 Fluid Intake" with a last review date of December 2024, failed to reveal how the facility would manage fluid intake for residents with physician ordered restrictions. Review of Resident 50's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart), and chronic respiratory failure with hypoxia (long-term condition	F 0692		

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F 0692 SS=E	Continued from page 38 in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body). Review of Resident 50's clinical record revealed a physician order for no added salt /1500 CC (cubic centimeters) FR [fluid restriction] diet Regular texture, Regular Liquids consistency, small portions at meals, dated November 16, 2024. Further review of Resident 50's clinical record failed to reveal how the Resident's fluid restrictions would be distributed throughout a 24-hour time period or how the facility would monitor Resident 50's overall fluid intakes on a daily basis. Review of Resident 50's clinical record nurse aide task documentation for fluid intake with meals and additional fluids provided from March 4, 2025 -April 1, 2025, revealed that Resident 50's was documented as consuming a total of 3370 cc on March 7, 2025; and 1560 cc's on March 25, 2025.	F 0692		

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F 0692 SS=E	Continued from page 39 Review of Resident 50's Medication Administration Records from November 2024 through April 1, 2025, failed to include any documentation of how much fluid was provided to Resident 50 during medication administrations on any shift. Review of Resident 50's clinical record progress notes failed to reveal documentation that her physician was made aware of her exceeding her ordered fluid restrictions on March 7 and 25, 2025. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on April 3, 2025, at 11:08 AM, the DON confirmed that there was no documentation of how many fluids were being provided by nursing staff with medication passes or nurse monitoring of total fluids consumed in a 24-hour period. She indicated that on March 7, 2025, she believed her fluid intake was a documentation error as Resident 50 does not generally consume that amount of fluid and that there were no notes indicating any change in her status. She confirmed that there was no documentation that	F 0692		

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F 0692 SS=E	Continued from page 40 Resident 50's physician was notified of her exceeding her fluid restriction on March 25, 2025. In addition, she confirmed that Resident 50 should have had a fluid breakdown in a 24-hour period to include meals, medication passes, and other offerings, established with nurse monitoring of fluids on a daily basis when the order was initially given for the fluid restriction. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 41 483.25(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. Upon discovery, the R 50 had their tubing dated and bagged 2. No other residents were identified with missing tubing or bags. Education was provided by the DON/designee on proper labeling and storage of respiratory equipment, 3. An audit will be conducted for 5 patients on respiratory equipment weekly x 2 weeks then monthly x 2 months to ensure that respiratory equipment is properly stored and dated. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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F 0695 SS=D	Continued from page 42 Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of three residents reviewed for respiratory care (Resident 50). Findings include: Review of facility policy titled "CLIN-009 Aerosol Therapy," with a last review date of December 2024, revealed: "Following the treatment remove any medication left in the medication cup of the nebulizer. Wash the nebulizer with tap water after shaking excess medication from assembly, then disassemble nebulizer and place on a paper towel and allow to air dry. Rinse the mask and/or mouthpiece with warm water for 30 seconds. Also air dry on a clean paper or towel. When nebulizer equipment is dry, place it back in labeled plastic bag. Plastic bag will have the date that the equipment was opened on the outside of the bag.	F 0695		

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F 0695 SS=D	Continued from page 43 Once a week, replace all disposable parts." Review of Resident 50's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart), and chronic respiratory failure with hypoxia (long term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body). Review of Resident 50's clinical record revealed a physician order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams/3 milliliters inhale orally via nebulizer four times a day, dated February 11, 2025. Further review of orders failed to include frequency of nebulizer tubing/mask change or frequency of cleaning of medication chamber/mask.	F 0695		

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F 0695 SS=D	Continued from page 44 Observations of Resident 50's room on April 1, 2025, at 10:25 AM, and April 2, 2025, at 11:48 AM, revealed that the tubing connected to her nebulizer machine was not dated and that the mask was laying on top of the machine with a plastic storage bag located beside the nebulizer. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on April 2, 2025, at 12:55 PM, the DON indicated that she would expect the nebulizer tubing to be dated and mask to be bagged when not in use. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0695		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 45 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	1. Upon discovery R24's behavior monitoring with the type of behavior being exhibited and the side effect monitoring were updated on the MAR 2. A baseline audit was completed on residents receiving psychotropic medications to ensure that behavior monitoring and side effects were listed on the MAR, Education was provided by the DON/designee to the licensed clinical staff to ensure that when psychotropic medications are ordered that behavior monitoring and side effects are present on the MAR when the order is entered. 3. An audit will be conducted by the DON/designee on 5 patients on psychotropic medications weekly x 4 weeks to ensure that behavior monitoring and side effects are present on the MAR 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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F 0758 SS=D	Continued from page 46 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=D	Continued from page 47 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to adequately monitor psychotropic medications to ensure that residents were free from unnecessary medications for one of five residents reviewed for unnecessary medications (Resident 24). Findings include: Review of facility policy, "Use of Psychotropic medications," revised January 21, 2025, revealed, "Complete 'Behavior/Interventions' Sheet or other behavior tracking pharmacy form to include : All relevant resident data, target behavior, record the number of episodes, intervention code and outcome by shift, if side effects observed enter code, otherwise leave blank." Review of Resident 24's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395918	A. BLDG: 00 B. WING:	04/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: **100902**	**55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201**

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F 0758 SS=D	Continued from page 48 life) and anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events). Review of Resident 24's physician orders revealed an order for risperidone (antipsychotic medication) for dementia, effective March 20, 2025. Review of Resident 24's clinical record failed to reveal evidence of side effect monitoring related to use of her antipsychotic medication or monitoring of the target behaviors the medication was to address. During an interview with the Director of Nursing on April 3, 2025, at 12:55 PM, she confirmed that behavior and side effect monitoring was not in place related to Resident 24's use of risperidone, but should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0758		
F 0806 SS=D		F 0806		

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 0806 SS=D	Continued from page 49 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 0806	1. At time of discovery, R 32 had an incident report completed, notifications and follow up was also completed as well as immediate education to E5 that served the roll and cheese. There were no adverse outcomes from a gluten free and lactose free resident eating ½ a dinner roll and cheese. 2. Education has been provided by the Dietary manager to the dietary staff on reading tray card tickets to ensure the proper diet is provided. No other residents have been identified as being served food that they may have allergies and/or intolerances to. 3. An audit will be conducted by the Dietary manager/designee on 5 patients tray cards to tray weekly x 2 weeks then monthly x 2 months to ensure that the proper diet is being sent to the resident. 4. Results of the audit will be taken to QAPI for review of findings and	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395918	A. BLDG: __00_____ B. WING: _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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STATE LICENSE NUMBER: **100902**	

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F 0806 SS=D	Continued from page 50	F 0806	further interventions if indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395918	A. BLDG: __00_____ B. WING: _____	04/03/2025

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F 0806 SS=D	Continued from page 51 Based on observation, clinical record review, review of select facility documents, and staff interviews, it was determined that the facility failed to ensure that residents were served food that accommodated their allergies and intolerances for one of 17 residents reviewed (Resident 32). Findings include: Review of Resident 32's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident 32's physician's orders revealed an order for a gluten free, lactose free diet effective July 7, 2023., Observation of Resident 32 on March 31, 2025, at 12:51 PM, revealed she was served and consumed	F 0806		

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 0806 SS=D	Continued from page 52 a cheeseburger on a bun. During an interview with Employee 5 (Dietary Aide) on March 31, 2025, at 12:58 PM, she confirmed that she had not served Resident 32's burger on a gluten free bun. She also confirmed that she has mistakenly served Resident 32 cheese on her burger. Review of Resident 32's meal ticket (paper slip that accompanies resident's meal tray that indicates allergies, preferences, and food/drink items to be received) for lunch on March 31, 2025, revealed that she was to be served a gluten free, lactose free diet. During an interview with the Nursing Home Administrator on April 3, 2025, at 10:56 AM, he revealed the expectation that Resident 32 should have been served the appropriate diet. He also revealed that education was provided to staff. 28 Pa. Code 201.18(b)(1)(e)(1) Management	F 0806		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0812 SS=E	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. E5, E6, E7 and E8 were provided education on using gloves or tongs when handling resident food. 2. Education will be provided by the DON/designee to the nursing and dietary staff on food handling. 3. An audit will be conducted by the DON or designee during 2 breakfasts, 2 lunches, and 2 dinners weekly x 4 weeks to ensure proper food handling during meal service. 4. Results of the audit will be taken to QAPI for review of findings and further interventions if indicated.	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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F 0812 SS=E	Continued from page 54 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure food was prepared and served under sanitary conditions in two of two dining rooms observed (1st and 2nd floor). Findings include: Review of facility policy, "Bare Hand Contact with Food and Use of Plastic Gloves," dated 2021, revealed, "Bare hand contact with food is prohibited...Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single-use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning work with food) and after removing single-use gloves. Gloves are just like hands. They get soiled. Anytime a contaminated surface is	F 0812		

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F 0812 SS=E	Continued from page 55 touched, the gloves must be changed, and hands must be washed." Observation of tray line service on second floor on March 31, 2025, at 12:38 PM, revealed Employee 7 (Dietary Aide) wearing gloves, touching the paper meal tickets, then reaching into the bag of hamburger buns to retrieve them wearing the same gloves, and touching cheese slices wearing the same gloves. Observation during lunch meal service on second floor on March 31, 2025, at approximately 12:40 PM, Employee 8 (Nurse Aide) brought a resident's plate back up to the serving line to have Employee 7 add a slice of cheese to the burger. Employee 8 was noted to use the tip of her right index finger to slide the top bun off the burger for Employee 7 to add the cheese. Employee 8 then slid the top bun back onto the burger using her same finger. Employee 8 was not wearing gloves. Observation in the first floor dining room on March	F 0812		

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 0812 SS=E	Continued from page 56 31, 2025, starting at approximately 12:40 PM, revealed Employee 6 (Nurse Aide) touching the sandwiches of Residents 26, 27, and 45 with her bare hands while assisting them with cutting and/or placing condiments on their sandwiches. Observation of tray line on first floor on March 31, 2025, at 12:44 PM, revealed Employee 5 (Cook) wearing gloves, touching the paper meal tickets, then reaching into the bag of hamburger buns to retrieve them wearing the same gloves, and touching cheese slices wearing the same gloves. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 2, 2025, at 12:43 PM, the DON confirmed that staff should have used tongs to serve hamburger buns and cheese slices, and that nursing staff should wear gloves when touching residents' food. During an interview with the NHA on April 3, 2025, at 10:56 AM, he revealed the expectation that staff	F 0812		

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F 0812 SS=E	Continued from page 57 should not be touching resident food with bare hands. 28 Pa. Code 211.6(f) Dietary services 28 Pa. Code 211.18(b)(1) Management	F 0812		

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P 1040	Responsibility of licensee. (c) The licensee through the administrator shall report as soon as possible, or, at the latest, within 24 hours to the appropriate Division of Nursing Care Facilities field office serious incidents involving residents as set forth in § 51.3 (relating to notification). For purposes of this subpart, references to patients in § 51.3 include references to residents. This REGULATION is not met as evidenced by:	P 1040	1. R48 ,was reported as required on 4/8/25 2. No other ERS reporting was identified as not submitted. Education was provided by the Regional Clinical nurse or designee to the new DON on ERS reporting requirements. 3. Incident reports will be audited by the DON or designees to ensure that any incidents requiring reporting is completed timely weekly x 4. 4. Audits will be taken to QAPI for review and further interventions if warranted	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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 1040	Continued from page 1 Based on clinical record review and staff interview, it was determined that the facility failed to report serious incidents within 24 hours to the Department of Health, Division of Regulatory Oversight Nursing Care Facilities for one of one residents reviewed (Resident 48). Findings include: Review of Resident 48's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and frequent falls. Review of Resident 48's clinical record revealed a progress note dated February 16, 2025, at 10:18 AM, revealing that he suffered a fall with a hematoma to the right side of his forehead, an	P 1040		

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 1040	Continued from page 2 abrasion to his right arm, and an abrasion to his left third finger, and was transferred to the hospital emergency department for further evaluation and treatment. Resident 48 was admitted to the hospital with a urinary tract infection. Further review of Resident 48's clinical record revealed a progress note dated February 23, 2025, at 10:05 PM, he suffered a fall with a bump on the right side of his forehead, a scratch down the length of his right arm, and that staff were unable to turn him without him yelling out in pain. The note further indicated that the nurse was unable to check his upper and lower extremities due to his inability to follow direction, that his physician was notified, and gave new order to send to the hospital emergency department for evaluation and treatment. Resident 48 was admitted with closed head injury and ambulatory dysfunction. Review of Resident 48's Hospital Discharge Summary dated February 26, 2025, indicated that Resident 48's hospital admission diagnoses were	P 1040		

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P 1040	Continued from page 3 closed head injury, fall, and ambulatory dysfunction. Review of the Pennsylvania Department of Health (DOH), Division of Regulatory Oversight Nursing Care Facilities' event reporting system revealed that the facility did not report either of Resident 48's transfers to hospital as a result of accident. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 3, 3025, at 1:40 PM, the DON confirmed that Resident 48's fall on February 16, 2025, should have been reported to the state. She further indicated that the fall on February 23, 2025, was not reported because his transfer to the hospital was not because of fall, but because staff could not evaluate him post-fall and was unable to redirect his behaviors. She said she was not told about the hematoma when she was notified of fall. She confirmed that he was admitted to the hospital because of ambulatory dysfunction.	P 1040		

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P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1. Facility identified no adverse outcome from days identified. 2. Education will be provided by the Administrator to the Nursing Administration, scheduler, and charge nurses on calculation of the ratios and replacement of staff if indicated. 3. Daily staffing meeting will be implemented with NHA, DON staff coord or designees to review staffing and appropriate ratios. If a call off occurs the Charge Nurse will contact Part Time and PRN staff, and contract agency staffing to meet staffing ratios. 4. A ratio audit will be completed by NHA or designee daily for 5 days then weekly x3. Audits will be taken to QAPI for review and further interventions if warranted	Completion Date: **05/13/2025** Status: **APPROVED** Date: **04/09/2025**

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 5530	Continued from page 5 Based on staffing document review and staff interview, it was determined that the facility failed to ensure a required minimum of one Licensed Practical Nurse (LPN) per 25 residents on day shift for one of 21 days reviewed (October 5, 2024). Findings include: Review of facility staffing ratio and resident census information for September 29, 2024 - October 5, 2024; December 29, 2024 - January 4, 2025; and March 27 - April 2, 2025, revealed a resident census of 63 on October 5, 2024. Further review revealed an LPN ratio of 2.13 worked during the day shift on that date, which did not meet the required minimum LPN ratio of 2.52 based on resident census during that shift. During an interview with the Nursing Home Administrator on April 3, 2025, he acknowledged that the facility did not staff that way but experienced a call off and were not able to fill the open slot.	P 5530		

Certified End Page

TRANSITIONS HEALTHCARE SHOOK HOME

STATE LICENSE NUMBER: 100902

SURVEY EXIT DATE: 04/03/2025

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
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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