

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 100902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on April 15, 2025, at Transitions Healthcare Shook Home, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

TITLE:

(X6) DATE:

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

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



Certified End Page

TRANSITIONS HEALTHCARE SHOOK HOME

STATE LICENSE NUMBER: 100902

SURVEY EXIT DATE: 04/15/2025

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: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 100902				
(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 0000	<p>INITIAL COMMENT</p> <p>Facility ID #100902 Component 01 Original Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 15, 2025, it was determined that Transitions Healthcare Shook Home it was determined there were no deficiencies identified under the 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).</p> <p>This is a three-story, Type II (111), protected noncombustible structure, without a basement, which is fully sprinklered.</p>	K 0000		

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

TITLE:

(X6) DATE:

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

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



Certified End Page

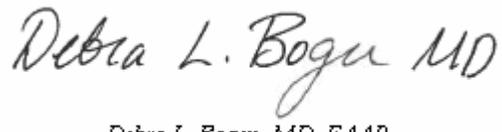
TRANSITIONS HEALTHCARE SHOOK HOME

STATE LICENSE NUMBER: 100902

SURVEY EXIT DATE: 04/15/2025

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: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
--	---	---	--

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

(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 0000	INITIAL COMMENT Facility ID #100902 Component 03 PT and Nursing Addition Based on a Medicare/Medicaid Recertification Survey completed on April 15, 2025, it was determined that Transitions Healthcare Shook Home was not in compliance with the following requirements of the Life Safety Code for a new 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 three-story, Type II (111), protected noncombustible structure, without a basement, which is fully sprinklered.	K 0000		
K 0225 SS=E		K 0225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0225 SS=E	Continued from page 1 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	1st and 2nd Floor Stairtower A doors will be corrected to be within the allowed gap margins. Maintenance Staff were educated on Stairways and Smokeproof Enclosures Stairways used as exits cannot have gaps greater than 1/8 gap. Director of Plant Operations or designee will audit 1 time a month. Audits will be reported at QAPI	Completion Date: 06/14/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 100902				
(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 0225 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain stairtower doors to be within the allowed gap margins, on two of three floors within the component. Findings include: 1. Observation on April 15, 2025, at 1:20 PM, revealed the 1st and 2nd floor Stairtower A doors had gaps greater than 1/8 inch. Interview with Director of Maintenance on April 15, 2025, at 1:20 PM, confirmed the door exceeded the allowed gap margins.	K 0225		
K 0321 SS=E		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
STATE LICENSE NUMBER: 100902				
(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 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to request a change of use for a hazardous area enclosures, affecting one of three floors within the component. Findings include: 1. Observation on April 15, 2025, at 1:50 PM, revealed the ground floor Pool Area was being used for storage of multi-medical record boxes and red isolation containers. Interview with the Director Maintenance on April 15, 2025, at 1:50 PM, confirmed the storage of hazardous items outside a 1-hour protected area.	K 0321		
K 0754 SS=E		K 0754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: 100902		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0754 SS=E	Continued from page 5 NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by:	K 0754	The three 96-gallon shredder containers were moved to an area with 1 hour protected rating. Maintenance staff was educated a 1-hour protected rating space is required for storage of soiled-linen and trash containers exceeding 32 gallons. Director of Plant Operations or designee will audit 1 time a week for a month; if compliance is achieved; then random audits monthly of soiled-linen and trash containers exceeding 32 gallons are stored in a 1-hour protected space. Audit results will be reported at QAPI.	Completion Date: 05/20/2025 Status: APPROVED Date: 04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395918	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/15/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE SHOOK HOME STATE LICENSE NUMBER: 100902		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 SOUTH SECOND STREET CHAMBERSBURG, PA 17201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0754 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to provide a protected space for soiled-linen and trash containers exceeding 32 gallons, on one of three floor within the component. Findings include: 1. Observation on April 15, 2025, at 1:35 PM, revealed three 96-gallon shredder containers were stored in the ground floor Lobby, which did not have a 1-hour protected rating. Interview with the Director of Maintenance on April 15, 2025, at 1:35 PM, confirmed the shredder containers were not being stored in a rated assembly.	K 0754		



Certified End Page

TRANSITIONS HEALTHCARE SHOOK HOME

STATE LICENSE NUMBER: 100902

SURVEY EXIT DATE: 04/15/2025

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