STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395348	A. Building B. Wing	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chambersburg Skilled Nursing and Rehabilitation Ce	1070 Stouffer Avenue Chambersburg, PA 17201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33305 Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure that residents were free from neglect, in regards to following the plan of care, which resulted in actual harm as evidenced by a non-operable nondisplaced fracture of the atlas (first bone in neck) and closed odontoid fracture (second bone in neck), for one of three residents reviewed (Resident 1). Findings include: A review of the facility's policy, titled Patient Protection: Abuse, Neglect, Mistreatment and Misappropriation Prevention, last reviewed May 13, 2022, states the definition of neglect, the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Review of Resident 1's closed clinical record revealed a history of diagnoses that included Type 2 Diabetes mellitus (a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and Cerebral Palsy (A congenital disorder of movement, muscle tone, or posture). Review of Resident 1's care plan for ADL self-care deficit initiated July 8, 2019, revealed an intervention to assist with two persons when rolling in bed and use of a bedpan; assist with one person when bathing, grooming, and dressing. Review of facility's incident report dated December 6, 2022, revealed that Resident 1 experienced a fall on December 6, 2022, at 5:15 PM. Further review of the incident report revealed Employee 1 was administering medications and observed the Resident was incontinent. Employee 1 initiated providing incontinence care. During care, Employee 1 called for assistance to Resident 1's room for a witnessed fall that occurred while rolling Resident 1 away from her during incontinence care. Employee 1 stated she was on the left side of the bed washing Resident 1's backside while Resident 1 was on his right side and slid off the bed falling face first onto the floor. No other staff were present in the room at the time of the fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's abuse investigation of the fall revealed that Employee 1 was educated on abuse and neglect on July 4, 2022. Employee 1, during the fall investigation interview, agreed that she shouldn't have rolled Resident 1 away from her without a second person present on the opposite side of the bed to assist with rolling the Resident and provide safety. Review of facility documentation revealed staff education related to following the resident's interdisciplinary plan of care was completed with all active nursing staff on December 16, 2022, and education will be provided to any PRN (as needed staff) prior to providing resident care. An interview with the Nursing Home Administrator (NHA), on December 27, 2022, at 2:00 PM, revealed the facility's investigation found the incident to be a confirmed instance of staff neglect, resulting in harm to Resident 1. On December 27, 2022, at 2:00 PM, the NHA stated that a plan of correction was initiated, based on the outcome of the facility's investigation, which determined that Employee 1 failed to follow the care plan for a two person assist while providing Resident care in the bed. The facility's education and audits were reviewed during the survey. On December 8, 2022, Employee 1 was educated to review all care plans prior to providing care to all residents. On December 8, 2022, through December 16, 2022, Education of staff and Agency staff of ADL (activities of daily living) care best practices, with return demonstration provided by team members, as well as Kardex review. PRN staff will be educated prior to providing direct care. On December 8, 2022, through December 16, 2022, Review of all resident care plans was conducted to ensure consistency and accuracy. On December 16, 2022, the station care plans were reviewed and updated as needed. On December 26, 2022, Weekly audits will be completed weekly for four weeks. Review of facility documentation revealed that on December 16, 2022, the facility had completed education for staff, competencies, house wide audit for all residents, and will continue weekly audits, to ensure compliance. During an interview with Employee 2 on December 27, 2022, at approximately 1:00 PM, Employee 2 confirmed that she received education on reviewing the care plan prior to providing care to residents, providing care to resident when in bed per the care plan and having two persons to assist when required. Employee 2 was also aware that when 1 person assist is required the resident should be rolled toward the staff. During an interview with Employee 3 on December 27, 2022, at approximately 1:10 PM, Employee 3 confirmed that she received education on reviewing the care plan prior to providing care to residents, providing care to resident when in bed per the care plan and having two persons to assist when required. Employee 3 was also aware that when 1 person assist is required the resident should be rolled toward the staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Prior to the abbreviated survey on December 27, 2022, the facility failed to provide two persons assist during rolling Resident 1 in bed, resulting in harm to the Resident. The facility reported the incident timely, investigated the incident thoroughly, and initiated interventions to prevent a future incident. Audits, staff education, incident reports, and resident care plans were reviewed. Resident record review and observations revealed no concerns with receiving the required assistance for the sampled residents. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure that each resident received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a non-operable nondisplaced fracture of the atlas (first bone in neck) and closed odontoid fracture (second bone in neck), for one of three residents reviewed (Resident 1). Findings include: A review of the facility's policy, titled Bed Positioning, obtained from 2022 [NAME] nursing procedures manual, the policy states to verify transfer assist needed per Kardex. Obtain additional assistance as indicated. Review of Resident 1's closed clinical record revealed a history of diagnoses that included Type 2 Diabetes mellitus (a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and Cerebral Palsy (A congenital disorder of movement, muscle tone, or posture). Review of Resident 1's care plan for ADL self-care deficit initiated July 8, 2019, revealed an intervention to assist with two persons when rolling in bed and use of a bedpan; assist with one person when bathing, grooming, and dressing. Review of facility's incident report dated December 6, 2022, revealed that Resident 1 experienced a fall on December 6, 2022, at 5:15 PM. Further review of the incident report revealed Employee 1 called for assistance to Resident 1's room for a witnessed fall that occurred while rolling Resident 1 away from her during incontinence care. Per Employee 1 who stated was on the left side of the bed washing Resident 1's backside while Resident 1 was on his right side and slid off the bed falling face first onto the floor. No other staff were present in the room at the time of the fall. The facility's investigation of the fall revealed that Employee 1 agreed that she shouldn't have rolled Resident 1 away from her without a second person present on the opposite side of the bed to assist with rolling the resident and provide safety. On December 27, 2022, at 2:00 PM, the NHA stated that a plan of correction was initiated, based on the outcome of the facility's investigation, which determined that Employee 1 failed to follow the care plan for a two person assist while providing Resident care in the bed. The facility's education and audits were reviewed during the survey. On December 8, 2022, Employee 1 was educated to review all care plans prior to providing care to all residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On December 8, 2022, through December 16, 2022, Education of staff and Agency staff of ADL (activities of daily living) care best practices, with return demonstration provided by team members, as well as Kardex review. PRN staff will be educated prior to providing direct care. On December 8, 2022, through December 16, 2022, Review of all resident care plans was conducted to ensure consistency and accuracy. On December 16, 2022, the station care plans were reviewed and updated as needed. On December 26, 2022, Weekly audits will be completed weekly for four weeks. Review of facility documentation revealed that on December 16, 2022, the facility had completed education for staff, competencies, house wide audit for all residents, and will continue weekly audits, to ensure compliance. During an interview with Employee 2 on December 27, 2022, at approximately 1:00 PM, Employee 2 confirmed that she received education on reviewing the care plan prior to providing care to residents, providing care to resident when in bed per the care plan and having two persons to assist when required. Employee 2 was also aware that when 1 person assist is required the resident should be rolled toward the staff. During an interview with Employee 3 on December 27, 2022, at approximately 1:10 PM, Employee 3 confirmed that she received education on reviewing the care plan prior to providing care to residents, providing care to resident when in bed per the care plan and having two persons to assist when required. Employee 3 was also aware that when 1 person assist is required the resident should be rolled toward the staff. Prior to the abbreviated survey on December 27, 2022, the facility failed to provide two persons assist during rolling Resident 1 in bed, resulting in harm to the Resident. The facility reported the incident timely, investigated the incident thoroughly, and initiated interventions to prevent a future incident. Audits, staff education, incident reports, and resident care plans were reviewed. Resident record review and observations revealed no concerns with receiving the required assistance for the sampled residents. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services