STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lofland Park Center	715 E. King Street Seaford, DE 19973

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews, record review and review of other facility records, it was determined that for one (R25) of eleven residents reviewed for accidents, the facility failed to provide an accident-free environment. R25 fell from a Hoyer lift onto the floor during a transfer due to improper use of the lift by two staff members. The Hoyer lift fell on R25's right knee. R25 complained of pain and was sent to the hospital for further evaluation and treatment. Due to the facility's corrective measures following this incident, this deficiency is being cited as past non-compliance with a corrected date of 1/9/26, which was verified through interviews and review of facility records. Findings include:10/22/25 - R25 was admitted to the facility.1/8/26 6:30 PM - A review of a facility incident report submitted to the Division documented R25 fell from the Hoyer lift at this time.1/8/26 9:38 PM - A review of a facility incident report to the Division documented CNA notified nursing that [R25] had fallen from the Hoyer. Further review of the report indicated R25 complained of feeling a snap in the back, and right knee pain due to the Hoyer lift falling on the R25's right side.1/14/26 - A review of the facility's five day follow up submitted to the Division documented that E5 (CNA) reported assisting E6 (CNA) with transferring R25 from the chair to the bed. R25 was placed on the Hoyer pad and raised to waist level while E6 guided R25's legs. E5 further reported closing the base of the Hoyer lift slightly because the room was tight, causing Hoyer to tip over. E5 stated an attempt was made to reopen the Hoyer, but the attempt was unsuccessful. E5 further reported that R25 landed on the floor and the bars of the Hoyer lift struck R25's legs.1/8/26 6:46 PM - A facility SBAR (Situation, Background, Assessment, and Recommendation) form documented recommendation to perform neurological checks and send R25 to the hospital.1/8/26 11:30 PM - R25 returned to the facility.1/9/26 3:17 AM - A facility progress not for R25 documented, Pain, right lateral thigh; pain score 2; aching; non radiating R25 position was changed. Non medication interventions provided relief.1/9/26 6:03 AM - A review of R25's hospital Xray results of the right knee documented No acute fracture or dislocation. Degenerative changes primarily involving the medial compartment.6/29/26 12:42 PM - During a telephone interview E5 (CNA) reported [E6] (CNA) asked for assistance transferring [R25] to bed. I was operating the lift, and it was hard to move. The roommate's recliner chair was in the way, so I slightly opened the base of the Hoyer lift so [E6] could navigate the lift to the bed. [E6] was holding [R25's] legs while guiding the transfer. I noticed one wheel of the Hoyer lift lifted off the floor, and I tried to widen the base, but I couldn't. [R25] was waist high in the lift and I was turning it, the lift tipped over onto [R25]. I went down too while trying to prevent the fall. I was removed from the unit and received hands on training for the lift and safety.6/29/26 1:55 PM - During an interview, E6 reported I called [E5] to assist with putting [R25] back into the bed. [E5] was operating the Hoyer lift while I guided [R25's] legs. We didn't realize the other resident's recliner chair was in the way. The Hoyer started to tip over, and we both tried to stop it, but [E5] ended up going down on the floor too. The nurse was notified right away. E6 then stated, I was not allowed to assist another resident until I completed Hoyer lift and safety training and demonstrated competency.6/30/26 10:34 AM - During a telephone interview, E8 (RN) reported That was a long time ago I don't remember all the details. What I do recall is that I was immediately notified by one of the CNAs. although I don't remember which one. I assessed [R25], (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided education to [E5, E6] and other staff, and documented that education in my statement. I completed the SBAR form, and I know that [R25] was sent to the hospital. However, since this occurred in January, I don't recall all of the detail.6/30/26 9:15 AM- During an interview, E2 (DON) reported I was notified immediately. [E5 and E6] were removed from the unit. I wasn't sure whether the Hoyer lift malfunctioned, so the equipment was removed from the unit and tagged for inspection by maintenance. [E5 and E6] were not allowed to return to the floor until they completed and demonstrated competency in the use of the Hoyer lift.The facility's immediate action included:1/8/26 6:30 PM - The attending on-call provider was notified.1/8/26 6:37 PM - R25 was transferred to the hospital by 911.1/8/26 6:45 PM - R25's family was notified.1/8/26 - A facility form titled Quality Assurance & Assessment was completed by E5 and E6.1/8/26 - The mechanical Hoyer lift was removed from the unit, and a lockout/ tagout device was applied pending inspection by maintenance. on the lift for maintenance to inspect.1/9/26 - E5 and E6 completed hands-on training, a skills check list, return demonstration, and re-education on the proper use of the Hoyer lift, gait belt, and safe resident handling using mechanical lifts.1/9/26 1:19 PM - A maintenance work order documented, Lift needs inspected for safety function. The lift was inspected, no defects were identified and the lift was returned to service.6/30/26 - The facility's response to R25's fall, which resulted from the improper use of the Hoyer lift by staff, included removing the Hoyer lift from service for inspection. E8 documented education provided to E5, E6 and other staff assigned to the unit following the incident. E5 and E6 were removed from resident care duties, until they successfully completed hands-on competency training for Hoyer lift transfers and gait belt use. Interviews with E5 and E6, along with review of facility records, confirmed that the required education and competency validation had been completed.6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.