

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Neffsville Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2829 Lititz Pike Lancaster, PA 17601	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on facility documentation, clinical records review and staff interview, it was determined that the facility failed to provide care and services in accordance with professional standards when the facility failed to notify the physician of recommendations following a specialist consultation for one out of 1 resident reviewed (Resident 2). Review of Resident 2's clinical records reveal medical diagnoses that include: Spina bifida (a birth defect that mainly affects the spine), hydrocephalus (a complication that can be associated with spina bifida causing the abnormal buildup of the fluid that surrounds the brain), neurogenic bladder (a problem with the brain, nerves, or spinal column that causes loss of control of the bladder that can be associated with spina bifida), and neurogenic bowel (difficulty moving or controlling the bowels because of nerve damage that can be associated with spina bifida).Review of Resident 2's clinical record revealed an after-visit summary dated January 3, 2025 from a Spina bifida specialist to the attention of the Nursing Supervisor stating: Please see attached order for daily SS enema (soap suds enema: a medical procedure that involves administering fluid with soap or mild detergent into the rectum to flush out the contents of the bowel.)Review of Resident 2's clinical record revealed the following order recommendation from the provider at Spina Bifida Specialist: Perform a rectal soap suds enema daily with 300-500mL warm, soapy water, with a diagnosis of Neurogenic bowel to be started on 1/24/25.Review of Resident 2's facility record reveals no progress note reflecting Resident 2's consultation with the Spina Bifida clinic.Review of Resident 2's facility record reveals no contact with Resident 2's primary care provider communicating these new orders.Review of Resident 2's physician's history and physical note dated 2/26/2025 does not reflect being informed of any consultation recommendations.Review of resident 2's medication administration record (MAR) reveal that no order was entered for a soap suds enema to be started on January 24, 2025.During an interview on September 10, 2025 at approximately 2:00 p.m. with the DON, it was confirmed that there is no evidence that the consultation recommendations were addressed with the primary care provider for Resident 2.28 Pa Code 211.12(d)(5) Nursing Services</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on facility policy and procedure review, staff interview, clinical record review, and facility documentation review it was determine the facility failed to ensure that one of three residents reviewed was free from free from accidents and provided adequate supervision resulting in actual harm of a distal femur fracture of Resident 1. Findings include: Review of Resident 1's diagnosis list revealed a diagnosis of Obesity, history of falling, hip fracture, Muscle Weakness, CVA (Cerebral Vascular Accident- Stroke) and Dementia (group of conditions that cause a decline in cognitive function, including memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life). Review of Resident 1's Minimum Data Set (MDS-periodic assessment of resident needs) dated May 5, 2025, revealed the resident was cognitively intact. Review of Resident 1's Care Plan revealed a care plan for ADL (Activities of Daily Living-basic self-care tasks that individuals perform on a regular basis to maintain their health and independence) self-care performance deficit r/t (related/to) impaired mobility and CVA revealed an intervention initiated on October 22, 2024 indicating the resident requires extensive assistance of 2 staff participation to reposition in bed. Review of Resident 1's Care Cardex for bed mobility revealed the resident required extensive assistance of 2 staff participation to reposition and turn in bed. Resident 1's cardex was located in the room on the door of the closet. Review of Resident 1's Progress Notes revealed an Incident Note date September 1, 2025, at 7:47 a.m. indicating CNA (Certified Nursing Assistant) notified this nurse that the resident was on the floor around 0450 (4:50 a.m.). the resident was noted sitting on the floor besides (his/her) bed with (his/her) back towards the wheelchair. CNA provided care to the resident and left (him/her) in a lateral (side laying) position to look for a drop sheet 10 minutes before. The resident complained of pain in (his/her) right knee. The resident said: I slipped out of bed and hit my knee, and I can't reposition it.the resident was transferred to (his/her) bed with three assistants by mechanical lift. Further review of Resident 1's progress notes revealed an entry dated September 2, 2025 at 9:35 a.m. indicating IDT (Interdisciplinary Team - group of diverse professionals with different areas of expertise who collaborate to achieve a common goal, often to provide coordinated, holistic care for complex needs, particularly in healthcare) reviewed residents fall from bed on 9/1/25. Resident reported (he/she) had moved (his/her) leg too far off of the bed when (his/her) side was lying on (his/her) side and the slid out of bed onto the floor. Resident c/o (complained of) pain in right knee and had limited mobility, noted to be externally rotated (indicative of a fracture of the femur) Resident admitted to the hospital with distal femur fracture (knee). Review of facility documentation into the investigation of the cause of the fall revealed a statement from Nursing Assistant Employee E3, dated September 1, 2025. I went into the residents room about 0435 to clean and wash and dress resident. After washing and dressing (him/her), (he/she) began to have a bowel movement. Resident was on (his/her) side in the middle facing the window and I asked if (he/she) was ok while I went to grab more towels. I lowered the bed and went to grab the linen off the cart in the hallway I could hear (him/her) yelling help. I went into the resident's room, and (he/she) was on the floor in the sitting position. I asked (him/her) what happened, and (he/she) stated (his/her) leg went too far over (the edge of the mattress) and (he/she) slipped out of bed. Interview with the Nursing Home Administrator and the Director of Nursing on September 10, 2025, at 2:00 p. m. confirmed Resident 1 was not provided appropriate staff supervision during care while Employee E3 left the bedside to get more towels while providing incontinence care which resulted in actual harm to Resident 1 who was admitted to the hospital for a fractured femur. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		