

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395224	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Hamilton Arms Center		STREET ADDRESS, CITY, STATE, ZIP CODE 336 South West End Avenue Lancaster, PA 17603	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon review of facility policy and procedure, review of facility documentation and clinical record review, it was determined that the facility failed to ensure residents were free from abuse and neglect resulting in actual harm to one resident (Resident R1). This was identified as past non-compliance for Resident R1. Findings include: Review of facility policy and procedure titled Preventing, Recognizing and Reporting Abuse revealed Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical pain or mental anguish. Further review of this policy revealed Neglect refers to failure through inattentiveness, carelessness or omission to provide timely, consistent, safety adequate and appropriate services, treatment of care, including but not limited to nutrition, medication, therapies and activities to daily living. The absence of reasonable accommodations of individual needs and preferences may result in resident neglect. Review of Resident R1's diagnosis list revealed diagnoses including morbid obesity, Diabetes Mellitus (failure of the body to produce insulin to enable sugar to pass from the blood stream to cells for nourishment), muscle weakness, presence of artificial knee joint and cognitive decline. Review of Resident R1's care plan dated November 23, 2022, revealed Resident R1's transfer status as Sit-to-Stand Lift. Review of Resident R1's Quarterly Minimum Data Set (MDS- periodic assessment of resident needs) revealed Resident R1 was noted to require substantial maximum assistance needed and used mechanical lift for transfer. Review of facility documentation dated June 27, 2026, revealed CNA (certified nurse aide) reported during transfer to shower chair staff lowered resident to the floor. CNA also reported that the shower chair and misjudged the height of the shower chair during transfer. Further review of facility documentation dated June 27, 2026, revealed statement by Nursing Employee E3; Myself and another aide were trying to transfer resident into shower chair (stand pivot) resident not high enough to reach shower chair seat and chair doesn't lock. Chair slid while trying to lift resident into chair. Had to lower her to the floor. Used lift to put back into bed. Resident c/o [complained of] left knee pain. Notified nurse of incident and complaint of pain. Resident does not do well with stand aide complains of shoulder pain with stand aide. Further review of facility documentation dated June 29, 2026, revealed statement by Employee E4; I was responding to a call bell when I saw the other CNA struggling to transfer resident from the bed to the shower chair. I tried to assist by moving the shower chair closer. We lowered the resident to the floor. I went to get the lift and pad. On Sunday I was reminded not to move a resident that fell/was guided to the floor until assessed. We put the resident on the bed and I think the other CNA reported it to the nurse. Further review of facility documentation revealed Employee E3 failed to use a sit to stand lift for Resident R1 as indicated on Resident R1's care plan. Employee E3 failed to report the fall to the nurse prior to moving the resident from the floor back to the resident's bed and failed to inform administration (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	Resident R1 did not like to utilize the sit-to-stand mechanical lift related to shoulder pain. Review of information submitted to the Department on June 28, 2026, revealed a PB-22 (report of Investigation of Alleged Abuse, Neglect, or Misappropriation of Property) submitted on July 1, 2026, indicated the facility substantiated neglect and terminated Employee E3 on June 29, 2026. Further review of facility documentation dated June 29, 2026, revealed statement by licensed nursing Employee E5 indicating CNA's at 1445 (2:45 p.m.) had reported a fall, after CNA's attempted to transfer resident to a shower chair. Shower chair was reported brakes not secure, resident slid and was lowered to the floor in (their) room. CNAs were then able to transfer resident back to (his/her) bed at the time of the incident. Review of Resident R1's clinical progress notes dated June 27, 2026, at 3:55 p.m. revealed called and spoke with [nurse practitioner] to report clinical finding to provider. Provider acknowledges and has ordered a STAT left knee x-ray, ice and elevation to the left knee and PRN [as needed] Lidocaine patch. Orders placed. Also called and spoke with [mobile x-ray] notified of STAT left knee x-ray order and face sheet printed for the x-ray provider. Review of x-ray report dated June 27, 2026, at 6:39 p.m., revealed there is a comminuted fracture of the distal femur in the supracondylar region with separation displacement anteriorly and posteriorly up to 3-4 millimeters. There is soft tissue swelling. Knee prosthesis in place. Acute comminuted distal femoral diaphyseal supracondylar fracture as discussed above with soft tissue swelling. Review of Resident R1's clinical record revealed Resident R1 was transferred to an acute care facility for surgical intervention for the femur fracture on June 27, 2026, at 9:40 p.m. and was readmitted to the facility on [DATE]. Interview with the Nursing Home Administrator and Director of Nursing on July 20, 2026, at 11:00 a.m. confirmed Employee E3 failed to follow Resident R1's care plan by failing to utilize the sit-to-stand mechanical lift for transfers resulting in a fall causing a fractured femur, failed to request additional staff prior to attempting transfer as required, and failed to timely report Resident R1's fall to the nursing supervisor. The facility failed to ensure Employee E3 followed Resident R1's active plan of care prior to transferring Resident R1 from the bed to the shower chair causing a fall resulting in actual harm of a femur fracture of Resident R1. The facility self-identified deficient practice at the time of the incident on June 27, 2026. The facility implemented a corrective action plan of staff education regarding what constitutes abuse and neglect and resident transfers. The facility's immediate action plan included: Ad hoc QAPI meeting on June 28, 2026. On-the-spot in-service was initiated with on-duty staff regarding Registered Nurse notification before moving a resident on the floor, what constitutes a fall, following the plan of care for transfers, any concerns regarding transfer status must be communicated to the nurse and if any concerns with equipment the equipment must immediately be taken out of service and a work order must be initiated. Facility shower chairs were inspected to ensure working brakes. The Staff Development nurse provided education to current staff on the facility Abuse and Neglect policy. Staff who were not educated by July 1, 2026, will not be permitted to work until their education is completed. The Director of Nursing and/or designee will complete audits of observation of resident transfers to ensure the residents' care plans are followed. Audits will be completed daily for one week and weekly for three weeks. The results of all audits will be reviewed by the QAPI committee. The corrective action plan was completed and verified through review of education documentation, interviews, and observation. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services		