STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395406	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Acres Manor	400 Saint Luke Dr Lititz, PA 17543

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of observations and resident and staff interviews it was determined that the facility failed to provide activity of daily living (ADL) assistance for ten of eighteen residents (Residents R1, R3, R4, R5, R6, R7, R8, R9, R10, and R11).Findings include: During an observation on 8/7/25, at 10:38 a.m. when asked if she needed to wait an extended amount of time when she requests assistance with care, Resident R3 stated, Frequently on third shift. During an observation on 8/7/25, at 10:42 a.m. when asked if she needed to wait an extended amount to time when she requests assistance with care, Resident R4 stated, Depends on the aide. If we have agency people, then we wait. During an observation on 8/7/25, at 10:57 a.m. when asked if she felt the facility maintained an adequate number of staff, Resident R1 stated, Yes and no. I don't think there are enough of them in the evening. During an observation on 8/7/25, at 12:08 p.m. when asked if he needed to wait an extended amount to time when she requests assistance with care, Resident R4 stated, It takes a long time to get back into bed if you get out. Review of facility grievances filed in May 2025, through July 2025, revealed the following: -On 5/9/25, Resident R6 had voiced a concern that he had rung his call light on 5/8/25, at 6:00 a.m. and staff did not respond. Resident R6 stated that he had to use the bathroom unassisted. -On 5/19/25, Resident R7's family member had voiced a concern on third shift (overnight) and weekends the call bell response time was too slow, and that staff are verbally short when responding (on 3rd shift). She stated that he was offered a urinal to use despite not being able to use it without spilling. -On 5/23/25, Resident R8 had voiced a concern that on 5/22/25, his call bell was answered in excess of 1.5 hours. He stated that he activated his call bell at 6:50 a.m. and that he did not receive care until 8:30 a.m. -On 6/16/25, Resident R9's family member had voiced a concern that when she arrived on 6/14/25, she found her mother in the bathroom with bowel movement all over the floor, and no trashcan liner in the trash. She was here with her mother who was in the bathroom ringing to get off the toilet for 15 minutes. During that time, she stated there were many call bells on in the hallway in which she observed staff walking by the call bells and other staff sitting a the nurses stations. She stated she observed many staff sitting at the nurses' station all weekend not answering call bells. She also stated she addressed the call bell issue with (an employee) and he told her that her mother is not the only resident then chuckled. -On 7/7/25, Resident R10's family member had voiced a concern stating, that today her mom was ringing to go to the bathroom, and no one answered her call bell. Resident too herself to the bathroom and rang the bathroom bell as well to get out again and no one came. Daughter approached a woman in blue scrubs regarding the call bell and was told not to expect help when passing trays during mealtime. -On 7/14/25, Resident R11's family member had voiced a concern regarding the length of time it takes to get her call bell answered. This seems to be more of a problem on evening or nights. -On 7/14/25, Resident R9's family member had voiced a concern She was here visiting over the weekend on Saturday on 2nd shift, her mom was ringing her call bell to go to the bathroom. 30 minutes passed and no one came to assist her mother, so she ended up taking her mother to the bathroom herself. She was incontinent and completely soaked, through her clothes and the recliner chair. She stated she was here for 3 hours on Sunday and no one stopped in to even check on her mom in the 3 hours she was visiting. She has stated she is disappointed in the care her mother is currently getting versus the last stay here with us. Visiting family members have mentioned concern over the care she is currently getting. [Family member] stated that the nursing staff have time to sit and play on their phones or sit and mingle with each other but don't have time to care for her mother whom she has found completely saturated more than once now. During an interview on 8/7/25, at approximately 1:15 p.m. the Nursing Home Administrator confirmed the facility failed to provide activity of daily living assistance for ten of eighteen residents. 28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and resident and staff interview, it was determined that the facility failed to provide prescribed treatment and services related to the wounds for two of six residents (Resident R1 and R2). Findings Include: Review of the facility policy General Wound Management dated 7/22/25, indicated, Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 6/24/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a physician's order dated 7/25/25, indicated, Cleanse RLE (right lower extremity) skin tear with NSS (normal saline solution), apply calcium alginate (highly absorptive, non-occlusive dressings made of soft, non-woven calcium alginate fibers derived from brown seaweed or kelp) to wound bed and cover with foam dressing daily & PRN (as needed) every day shift. During an observation on 8/7/25, at 10:52 a.m. the dressing on Resident R1's right lower extremity was dated 8/5/25. Review of Resident R1's TAR (treatment administration record) revealed documentation that Resident R1's RLE dressing change was completed by Licensed Practical Nurse (LPN) Employee E1 on 8/6/25. Review of the clinical record revealed Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and history of a stroke. During an observation on 8/7/25, at 11:01 a.m. an undated dressing was noted on Resident R2's left lower leg. Review of a progress note dated 7/28/25, at 9:57 a.m. indicated, CNA (nurse aide) reported to this LPN that patient had open area on his L shin. Area measured 3 x 2.5 x 0.1 cm (centimeters). LPN applied xeroform (fine mesh gauze) and bordered foam dressing after cleansing. Further review of Resident R2's progress notes failed to reveal that the open area on his left shin was assessed by a provider. Review of Resident R2's physician orders failed to reveal a treatment order for Resident R2's left lower leg. During an interview on 8/7/25, at approximately 1:15 p.m. the Nursing Home Administrator confirmed that facility failed to provide prescribed treatment and services related to the wounds for two of six residents. 28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 211.10 (c)(d) Resident care policies28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services