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	06/29/2026

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 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 on review of facility policies, clinical record, facility documentation and interviews with staff, it was determined the facility failed to ensure a resident remained free from neglect, which resulted in actual harm to Resident R5 who sustained a left leg periprosthetic femur fracture for one of five residents reviewed (Resident R5). Findings include:Review of facility policy Resident Abuse Prevention and Reporting dated July 22, 2009, with a last revision date of November 28, 2016, and November 29, 2016, defines Neglect as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of Resident R5's MDS (Minimum Data Set - mandatory periodic assessment) dated May 8, 2026, revealed Resident R5 was readmitted to the facility on [DATE], with the diagnoses of unspecified fall, repeated falls, other abnormalities of gait and mobility, cognitive communication deficit, and need for assistance with personal care. Additional review revealed Resident R5's toilet transfer status is Substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Continued review revealed the resident was severely cognitively impaired with a Brief Interview of Mental Status of a 7 out of 15. Review of Resident R5's care plan, date-initiated April 20, 2026, revealed the resident ambulation status is non-ambulatory.Further review of Resident R5's care plan revealed the resident was designated by the facility to be at risk for falls. Interventions included anticipate and meet the resident's needs.Review of documentation submitted on June 17, 2026, to the State Survey Agency revealed on June 14, 2026, Resident R5 experienced a witnessed fall while Certified Nursing Assistant, Employee E3 was assisting Resident R5 from the bathroom ambulating without a walker or gait belt when resident's left knee buckled, causing her to lower herself to the floor. Nursing staff assessed Resident R5 following the fall, documented left knee discomfort and inability to straighten her leg, notified the physician and Power of Attorney (POA), obtained an X-ray, and implemented pain management interventions (ice pack). The X-ray results documented a knee prosthesis in place without loosening, with an effusion and no fracture identified at that time. On June 16, 2026, Resident R5 was transferred to a nearby hospital and admitted with a diagnosis of a left periprosthetic femur fracture (fracture occurring around or near a hip replacement implant).Review of the facility-submitted PB-22 (Report of Investigation of Alleged Abuse, Neglect, or Misappropriation of Property), initiated June 16, 2026, revealed Resident R5's ambulation status was noted to be non-ambulatory and Resident R5, should not have been ambulated by Certified Nurse Aide, Employee E3.Further review of the PB-22 revealed the facility substantiated the allegation of neglect and concluded Resident R5 experienced neglect as a result of Certified Employee E3's actions.Review of facilities fall investigation revealed the following transcript between the Nursing Home Administrator (NHA) and Certified Employee E3, dated June 17, 2026, at approximately 2:35 p.m. Certified Employee E3: We (E3 and Resident R5) went into the bathroom and when we were walking back we right by resident's bed. I turned my head to turn the light off and he/she went down on his/her behind. He/she went down so fast I didn't have time to grab him/her. I was trying to make sure he/she didn't hit his/her (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	head on the footboard.NHA: Do you know what his/her ambulation status is on his/her Kardex?Certified Employee E3: One assist with walker.NHA: Do you remember the last time you looked at resident's Kardex?Certified Employee E3: No I don't - I'm not sure, I just know I was told he/she is a 1 assist with walker.NHA: Who told you he/she is a 1 assist with a walker?Certified Employee E3: I don't know - someone when he/she was admitted .NHA: Do you know her transfer status on her Kardex?Certified Employee E3: A one assist - I'm always there with him/her.NHA: Does a one assist require hands on assistance?Certified Employee E3: Is she needs assistance - I am there to assist. But I am always standing right there.NHA: Were you using a gait belt?Certified Employee E3: NO - I was not using a gait belt.Certified Employee E3: So, we are supposed to check the Kardex every shift!?NHA: Yes, that was the expectation- actually, the Kardex should be checked multiple times a shift as things can change.Certified Employee E3: We don't have time for that.Further review of the investigation transcript revealed Certified Nurse Aide, Employee E3 was suspended pending the outcome of the facility's investigation. Documentation further revealed Employee E3 subsequently resigned effective immediately.Interview conducted with Resident R5 on June 29, 2026, at approximately 12:50 p.m. revealed Resident R5 recalled walking back from the bathroom when his/her knee gave out, causing him/her to fall to the floor. Resident R5 stated Certified Nurse Aide, Employee E3 did not prevent the fall.The above findings were discussed with the Nursing Home Administrator and Director of Nursing on June 29, 2026, at approximately 2:23 p.m.The facility failed to ensure Resident R5 was free from neglect. As a result, Resident R5 sustained a fall resulting in actual harm, including transfer to the hospital via emergency medical services and a diagnosis of a left periprosthetic femur fracture. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(e)(1) Management28 Pa. Code 201.18(b)(3) Management28 Pa. Code 201.29(c) Resident rights28 Pa. Code 211.5(f) Clinical records28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.11(d) Resident care plan28 Pa. Code 211.12(c)(d)(1)(5) Nursing services