STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395427	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home at Hollidaysburg	916 Hickory Street Hollidaysburg, PA 16648

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. 28177 Based on review of facility policies, investigative reports, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect caused by the failure to transfer a resident properly, resulting in a fractured arm for one of three residents (Resident 2) reviewed. This deficiency was cited as past noncompliance. Findings include: The facility's policy on freedom from abuse, neglect, misappropriation of property, exploitation and other suspicious crimes or events, dated January 11, 2024, indicated that each resident had the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; misappropriation of property; and involuntary seclusion. Every resident in the facility was to be treated with consideration, respect, and full recognition of his/her dignity and individuality, and management and staff were jointly and individually responsible to ensure each resident was free from abuse, neglect, and misappropriation of property. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident abilities and care needs) for Resident 2, dated May 3, 2024, revealed that the resident was sometimes understood and could sometimes understand, was cognitively impaired, required assistance for all care, and had diagnoses that included dementia. A care plan for Resident 2, dated August 17, 2021, indicated that the resident required assistance for all care. A nursing note for Resident 2, dated June 12, 2024, at 5:04 p.m. revealed that staff reported the resident had a bruise on her right arm. A registered nurse assessment was difficult because the resident was guarding her arm. The family and physician were notified and an order was received for an x-ray. A statement by Nurse Aide 4, dated June 12, 2024, at 5:00 p.m. revealed that her and Nurse Aide 5 transferred Resident 2 onto the toilet. Upon attempting to stand the resident to clean her behind, the resident was unable. They used the sit-to-stand lift (a mechanical device designed to assist individuals in moving from a sitting to standing position and vice versa) on the resident. She complained of pain in her arm and could not use it for the sit-to-stand transfer to stand back up. Nurse Aide 4 went and got Licensed Practical Nurse 6 and the three of them assisted the resident and sat her back down on the chair. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A statement by Nurse Aide 5, dated June 12, 2024, at 5:00 p.m. revealed that he and Nurse Aide 4 did a two-arm assist on Resident 2 to help her hold the bar to sit on the toilet. Resident 2 was unable to stand so they sat her on the toilet. Afterwards, they attempted to use the sit-to-stand lift to help her off the toilet, but she complained of pain in her right arm. Nursing was notified. A statement by Licensed Practical Nurse 6, dated June 12, 2024, at 5:00 p.m. revealed that she was called to Resident 2's room and the resident was on the toilet. Nurse Aides 4 and 5 were unable to get her off the toilet. A sit-to-stand lift was used. The resident was noted to have a hematoma of her right upper arm and complained of pain. A statement by Registered Nurse 7, dated June 12, 2024, at 5:10 p.m. revealed that Licensed Practical Nurse 6 brought Resident 2 to her to look at the her arm. The resident was complaining of pain, and there was a bruise on her right upper arm. The resident was holding her arm and did not want Registered Nurse 7 to move it. Registered Nurse 7 assessed the area and found bruising and some swelling. The physician was notified and an x-ray was ordered and scheduled for morning. A nursing note for Resident 2, dated June 12, 2024, at 9:15 p.m., revealed that nursing staff reported the resident's right arm was more swollen and more bruised. When Registered Nurse 7 attempted to assess range of motion, she felt bone grind against bone and immediately stopped and started the notification process. An order was received to transport the resident to the emergency room for evaluation and treatment. Resident 2 left the facility at 9:45 p.m. A nursing note for Resident 2, dated June 13, 2024, at 2:57 a.m., revealed that a call was received from the hospital to inform them that the resident was being admitted with a displaced fracture of the midshaft of the right humerus. The Director of Nursing was notified and arrived at the facility at 4:45 a.m. Investigation documents for Resident 2, dated June 13, 2024, at 10:15 a.m. revealed that the Director of Nursing made contact with Nurse Aide 4 for further questioning of what happened. Nurse Aide 4 refused to speak over the phone and wanted to come to the building. Nurse Aide 4 came to the building and provided new verbal and written statements revealing that she did not use a gait belt when transferring Resident 2 to the toilet with Nurse Aide 5. She stated that he transferred her by bear hugging her (when someone wraps their arms all the way around a person and squeezes tightly). The second written statement by Nurse Aide 4, dated June 13, 2024, revealed that on June 12, 2024, she brought Resident 2 into the bathroom to be toileted. She and Nurse Aide 5 planned on cleaning the resident because she could smell a bowel movement. Nurse Aide 5 bear hugged the resident so that Nurse Aide 4 could pull down her pants and her incontinent brief prior to sitting on the resident on the toilet. They cleaned and changed the resident's clothing as much as they could while she was on the toilet. Upon standing her up they noticed she was not able to do it. Nurse Aide 4 decided to get the sit-to-stand lift. After hooking her up and trying to put her arm up on the bar to lift her up, she complained of pain and could not move it. Nurse Aide 4 went and found Licensed Practical Nurse 6, and she came back and assisted them with a three-person transfer. Nurse Aide 5 supported her left side, Nurse Aide 4 supported her waist and lower back to help her stand better, and Licensed Practical Nurse 6 assisted with perineal, bowel and urine cleaning. They sat the resident down on her wheelchair. A couple hours later a coworker noticed more bruising and brought it to the attention of the Registered Nurse Supervisor, who assessed her arm and stated the resident needed to be sent out. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Investigative documents for Resident 2, dated June 13, 2024, at 11:10 a.m. revealed that the Director of Nursing made contact with Nurse Aide 5. His statement remained consistent with statement given the night of injury. He confirmed that he did not use a gait belt. The facility's investigation concluded on June 13, 2024, at 6:00 p.m. and determined the cause of Resident 2's injury to be from neglect. Review of Nurse Aide 5's personnel file revealed that he had completed training regarding preventing, recognizing, and reporting abuse on March 18, 2024. Following the investigation on June 13, 2024, the facility's corrective actions included: Nurse Aide 5 was terminated from employment at the facility. Staff education on abuse was completed. Audits to identify any issues with abuse were started. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on June 24, 2024. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.