STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395560	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Elizabethtown	One Masonic Drive Elizabethtown, PA 17022

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 - Minimal harm or potential for 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility documentation, and staff interviews it was determined the facility failed to ensure Resident CL1 was free from neglect for one out of four residents reviewed (Resident CL1). Findings Include: Observation conducted on August 25, 2025, at approximately 10:45 am of the [NAME] nursing unit spa room and whirlpool bath chair. Observation was conducted in the company of licensed staff, RN Supervisor, Employee E2 and RN Nurse Manager, Employee E3. The chair has a large width strap that is strung through a loop positioned between resident's legs and then fastened on opposing side. there are two padded metal bars positioned in front and behind resident. the front bar snaps into place, secure, once resident is positioned into place. Interviews conducted August 25, 2025, at approximately 10:50 am with Employee E3 (in presence of Employee E2, RN Supervisor). Employee E3 was the nursing staff called to assess and assist after incident and assessed resident for injuries. Employee E3 described the position she found the resident in the whirlpool tub and nurse aide's statement. Employee E3 found the resident face down on his/her left side. There was no water in the whirlpool tub, but the resident was wet. Further interview revealed that Employee E3 asked Employee E4 (nurse aide) what happened for resident to end up in this position. Nurse aide, Employee E4 stated that it happened too fast, but that resident slipped out of the whirlpool chair. Additional interview with Employee E3 and Employee E4 revealed the whirlpool chair has 2 types of safety apparatus on the chair. The witness statement of the nurse aide was reviewed but lacking details of timeline of events. The administrative staff including Director of Nursing (who was off at time of survey) asked the nurse aide to demonstrate how resident slid out of the whirlpool chair. Employee E2 felt that the nurse aide was confused by questions asked so she and Employee E3 demonstrated by placing themselves as re-enactors of the incident. The re-enactment revealed, if the resident was placed in chair with both seatbelt (secured through legs) and safety bars locked in place, the resident would not have been able to slide from the chair. Employees E2 and E3 indicated that the nurse aide only responded that the incident happened quickly so she is unclear of the details. Interviews conducted on August 25, 2025 at approximately 12:00 p.m. with nurse aides, Employees E5 and E6 revealed, staff are trained during orientation classes on how to properly secure a person in the whirlpool chairs. The staff are then trained on each specific chair once they are assigned to a nursing unit. The staff members are monitored and observed by senior staff during orientation period on the nursing unit including showers and whirlpool baths to ensure safety of residents and staff during bathing. Review of facility investigative document revealed, LPN reported resident had a fall in the whirlpool tub, CNA called LPN on phone to report fall, observed resident lying on her left side in the whirlpool tub, tub empty of water, CNA reported resident slid face forward from the mobility chair in thewhirlpool tub, CNA reported safety belt was in place, resident was assisted in whirlpool to to roll onto back, observed small hematoma to the forehead, abrasion to the L anterior knww, 2 abrasion to the L fifth toe, no s/s of pain or discomfort, resident denies pain or discomfort, no s/s of pain or discomfort with mobility or transfers, able to follow simple commands, answers yes or no questions, [NAME] within her baseline limitations, verbal and written re-education provided, POA notified via phone call, message sent to CRNP to call nursing unit for notification, neurological checks intact, VSS, area free from hazards, function of whilrpool, chair, and safety belt inspected for function, no malfunction noted, area with adequate lighting, resident was assisted out of tub with hoyer lift and assist of 3 to wheelchair, no pain or discomfort noted during transfer, resident was incontinent of BM at the time of the fall. Review of facility investigative documentation revealed, the staff member failed to follow procedure and care plan for resident. Review of facility documentation revealed the facility substantiated neglect by the nurse aide. Employee E4 was subsequently terminated from facility employment. Review of facility investigative documentation revealed a witness statement by nurse aide, Employee E4 as follows; To whom it may concern, on July 24, 2025, resident (Resident CL1) was in the tub chair when (he/she) slipped out of the tub chair. The statement was signed but not dated. Review of information submitted by the facility on July 24, 2025, at 12:45 p.m. to the Department of Health revealed, Aide was providing resident a whirlpool bath. After completing the bath, tub was emptied, resident fell forward from the tub chair face down, striking her head. She sustained a hematoma to forehead, abrasion to left knee, right and left toe, bruise to right lower leg and right and left calf. After further evaluation and inspection, everything was functioning properly, and it appeared that the aide failed to secure the safety belt and arm / lap bar which would have prevented the resident from falling