

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Sprenkle Drive		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Folkemer Circle York, PA 17404	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37013</p> <p>Based on facility policy review, clinical record review, review of facility investigation documentation, and resident and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect, which resulted in actual harm, as evidenced by a 4.5 cm (centimeter) x 4 cm skin tear (a wound that occurs when the skin separates from itself, usually due to trauma or friction) for one of five residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of facility policy, titled Limited Lift Environment Standard, most recently dated August 7, 2015, revealed Resident Transfer- Responsibilities: When a mechanical lift is used, two (2) team members are required.</p> <p>Review of facility policy, titled Abuse/Neglect Exploitation Prevention Standard for Skilled Care, most recently revised October 4, 2017, revealed Residents have the right to be free from verbal, physical, mental, sexual abuse, neglect corporal punishment and involuntary seclusion and exploitation. Neglect: 483.13(c) failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (42 CRF 488.301). 28 Pa Code 201.3 Definitions - the deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health. Act 13 of 1997 the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.</p> <p>Review of Employee 1's (Nurse Aide Trainee) form titled Performance Checklists for Nurse Aide Trainees/Students in Pennsylvania revealed that Explains the responsibility to identify, prevent and report abuse, exploitation, and neglect as legislated in Act 14 of 1997 (P.L.), the Nurse Aide Resident Abuse Prevention Training Act, was documented as being demonstrated by Employee 1 on September 30, 2024. This was marked S, meaning satisfactory, and was signed off on by Employee 2 (Nurse Aide Trainee Instructor).</p> <p>Further review of Employee 1's performance checklist revealed Follows nursing care principles to prevent client abuse, neglect, exploitation .Provides appropriate restorative care to prevent abuse, neglect, and exploitation, was documented as being demonstrated by Employee 1 on September 30, 2024. These were also marked S and signed off on by Employee 2.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's clinical record revealed diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness; cerebral infarction is a stroke), congestive heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), and Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Review of Resident 1's care plan revealed an intervention, revised September 15, 2023, stating that Resident 1's transfer status is by a sit-to-stand (a lift designed to assist individuals with limited mobility in transitioning from a seated to a standing position).</p> <p>Review of Resident 1's nursing progress note dated October 8, 2024, revealed that at 7:30 AM, Resident 1 was being transferred via standing lift into the bathroom. Residents back left arm was rubbed against door frame causing a 4.5 [cm] x4 cm skin tear. The note further stated that the skin tear was cleansed with normal saline solution, steri-strips (used to keep the edges of a cut together and help it heal) were applied and the area was covered with non-adherent gauze and was wrapped.</p> <p>Review of facility reported incident dated October 8, 2024, revealed that Employee 1 transferred Resident 1 independently using a sit to stand lift, causing a skin tear to the back of Resident 1's arm as a result of hitting it on the door frame during the transfer.</p> <p>Review of facility's investigation revealed that on October 8, 2024, Employee 1 was interviewed by the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 2.</p> <p>Review of the interview revealed that Employee 1 was completing morning care with Resident 1 and he requested to go to the bathroom. Employee 1 stated she went into the hall looking for a staff member but couldn't find anyone. She stated she went back into the Resident's room to tell him she couldn't find anyone, and that the Resident began to rush her. Since she was feeling rushed, Employee 1 decided to use the sit-to-stand lift independently. Employee 1 stated that the Resident said, something along the lines of don't you need someone with you. The interview further stated that Employee 1 admitted she did make the decision to transfer him, and she subsequently bumped his arm on the door frame causing a skin tear.</p> <p>Further review of the facility's investigation revealed that Resident 1 was interviewed by Employee 3 (Registered Nurse) on October 8, 2024.</p> <p>Review of Resident 1's interview revealed that Resident 1 stated 'That girl took me out of the bathroom and I bumped my elbow', 'I asked her don't you need help, and she told me she couldn't find anyone'.</p> <p>Review of a quiz taken by Employee 1 dated September 24, 2024, revealed the question For a safe transfer with a full mechanical lift, use at least , with the multiple choice answers being 1 assist, 2 assist, 3 assist or 4 assist. Employee 1 answered the question correctly by answering 2 assist.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Employee 1's form titled Performance Checklists for Nurse Aide Trainees/Students in Pennsylvania, revealed that Demonstrates the proper use of assistive devices, when assisting the client to: b. Transfer (such as mechanical lift, stand aid, etc.), was documented as being demonstrated by Employee 1 on September 30, 2024. This was marked S, meaning satisfactory, and was signed off on by Employee 2.</p> <p>During an interview with Resident 1 on October 23, 2024, at 12:35 PM, when asked about the incident on October 8, 2024, Resident 1 stated I told her [Employee 1] she needed help and she wouldn't listen. She said I was rushing her but I wasn't. I told her to go get help. Resident 1 stated that Employee 1 did not attempt to find someone to help her, and she transferred him alone, using the sit to stand lift.</p> <p>Review of facility's investigation findings revealed that Employee 1 admitted to the allegation and not following the care plan. Employee 1 was removed from the nurse aide training program and terminated from the facility.</p> <p>During an interview with the NHA and Employee 2 on October 23, 2024, at 11:03 AM, the NHA stated that every kind of lift used in the building requires two-person assist for use. It was also stated that Employee 1 knew she wasn't supposed to transfer Resident 1 alone, but did anyway, because she said she felt rushed.</p> <p>The facility failed to ensure that Resident 1 was free from neglect when Employee 1 did not follow Resident 1's care planned interventions for two-person assist with the sit-to-stand lift, resulting in Resident 1 hitting his arm on the door frame, causing a 4.5 cm x 4 cm skin tear.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37013</p> <p>Based on facility policy review, clinical record review, review of facility investigation documentation, and resident and staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a 4.5 cm (centimeter) x 4 cm skin tear (a wound that occurs when the skin separates from itself, usually due to trauma or friction) for one of five residents reviewed (Resident 1).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Limited Lift Environment Standard, most recently dated August 7, 2015, revealed Resident Transfer- Responsibilities: When a mechanical lift is used, two (2) team members are required.</p> <p>Review of Employee 1's (Nurse Aide Trainee) form titled Procedure Evaluation Checklist (Comprehensive), revealed on September 23, 2024, Employee 1 was marked off by Employee 2 (Nurse Aide Trainee Instructor) that Employee 1 Demonstrates Proper Use of Assistive Devices when Assisting the Client to Transfer Using a Mechanical Lift.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness; cerebral infarction is a stroke), congestive heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), and Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Review of Resident 1's care plan revealed an intervention, revised September 15, 2023, stating that Resident 1's transfer status is by a sit-to-stand (a lift designed to assist individuals with limited mobility in transitioning from a seated to a standing position).</p> <p>Review of Resident 1's nursing progress note dated October 8, 2024, revealed that at 7:30 AM, Resident 1 was being transferred via standing lift into the bathroom. Residents back left arm was rubbed against door frame causing a 4.5 [cm] x 4 cm skin tear. The note further stated that the skin tear was cleansed with normal saline solution, steri-strips (used to keep the edges of a cut together and help it heal) were applied and the area was covered with non-adherent gauze and was wrapped.</p> <p>Review of facility reported incident dated October 8, 2024, revealed that Employee 1 transferred Resident 1 independently using a sit-to-stand lift, causing a skin tear to the back of Resident 1's arm as a result of hitting it on the door frame.</p> <p>Review of the facility's investigation revealed that on October 8, 2024, Employee 1 was interviewed by the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 2.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the interview revealed that Employee 1 was completing morning care with Resident 1 and he requested to go to the bathroom. Employee 1 stated she went into the hall looking for a staff member but couldn't find anyone. She stated she went back into the Resident's room to tell him she couldn't find anyone, and stated that the Resident began to rush her. Since she was feeling rushed, Employee 1 decided to use the sit-to-stand lift independently. Employee 1 stated that the Resident said something along the lines of don't you need someone with you. The interview further states that Employee 1 admitted she did make the decision to transfer him, and she subsequently bumped his arm on the door frame causing a skin tear.</p> <p>Further review of the facility's investigation revealed that Resident 1 was interviewed by Employee 3 (Registered Nurse) on October 8, 2024.</p> <p>Review of Resident 1's interview revealed that Resident 1 stated 'That girl took me out of the bathroom and I bumped my elbow', 'I asked her don't you need help, and she told me she couldn't find anyone'.</p> <p>During an interview with Resident 1 on October 23, 2024, at 12:35 PM, when asked about the incident on October 8, 2024, Resident 1 stated I told her [Employee 1] she needed help and she wouldn't listen. She said I was rushing her but I wasn't. I told her to go get help. Resident 1 stated that Employee 1 did not attempt to find someone to help her and she transferred him alone, using the sit-to-stand lift.</p> <p>Review of facility's investigation findings revealed that Employee 1 admitted to transferring Resident 1 independently instead of using a two-person assist with the lift. Employee 1 was removed from the nurse aide training program and terminated from the facility.</p> <p>During an interview with the NHA and Employee 2 on October 23, 2024, at 11:03 AM, the NHA stated that every kind of lift used in the building requires two-person assist for use. It was also stated that Employee 1 knew she wasn't supposed to transfer Resident 1 alone, but did anyway, because she said she felt rushed.</p> <p>Employee 1 failed to provide the appropriate assistance level when transferring Resident 1 using a sit-to-stand lift, resulting in Resident 1 hitting his arm on the door frame, causing a 4.5 cm x 4 cm skin tear.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		