STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395697	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodland Park	18889 Croghan Pike Orbisonia, PA 17243

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42079 Based on a review of manufacturer's directions, clinical records, incident/accident reports, staff training records, and information submitted by the facility, as well as staff interviews, it was determined that the facility failed to ensure that safe techniques were used during a transfer onto a mechanical wheelchair lift for one of three residents reviewed (Resident 2), resulting in a head injury. Findings include: Manufacturer's directions for use of the [NAME] Corporation FMVSS Public Use Lift (the type of lift platform in the facility's wheelchair van), undated, indicated that the lift platform must be positioned at floor level when loading and unloading in and out of the vehicle. The lift operator would load and unload the wheelchair passenger on the lift and use the up and down switch to control the movement of the platform. A visual and audible warning would activate if the threshold area was occupied when the platform was greater than one inch below floor level of the van. The bus and van competency checklist for Nurse Aide/Transporter 1, dated November 30, 2023, revealed that staff received training prior to operating the electronic lift of the vehicle and demonstrated proper procedure for using the lift to load standard and electric wheelchairs. Nurse Aide/Transporter 1 met the standard to raise and lower the lift platform safely and in the correct position. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated June 21, 2024, revealed that the resident was cognitively intact, required extensive assistance from staff for her daily care including transfers, and used a wheelchair. A nursing note and incident report for Resident 2, dated June 26, 2024, at 3:26 p.m. revealed that the resident was lying on her left side on the pavement with her head on the lift platform that is used to load and unload residents from the van. Nursing notes for Resident 2, dated June 26, 2024, at 4:16 p.m. revealed that the resident had a skin tear on her right forearm and right foot, an abrasion on her right knee, scratches on her knuckles, and a 2.5 centimeter (cm) x 2.5 cm lump on the back of her head. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing note for Resident 2, dated June 26, 2024, at 5:06 p.m. revealed that the resident was sent to the hospital for a CT scan (diagnostic imaging test) after a fall with head injury. A statement from Nurse Aide/Transporter 1, undated, revealed that she unhooked the safety hooks, seatbelt, and wheelchair locks for Resident 2 and backed her up to the back of the van. Nurse Aide/Transporter 1 had to brace her feet to the safety hook bracket and pushed with her legs to pull Resident 2 over the lip of the lift because of her weight. Nurse Aide/Transporter 1 stepped back on the lift and realized that the lift was not in proper position. Nurse Aide/Transporter 1 attempted to push Resident 2 forward, but with the momentum the alarm plate flipped back towards her and both Nurse Aide/Transporter 1 and Resident 2 fell . Information submitted by the facility on June 27, 2024, revealed that Nurse Aide/Transporter 1 pushed Resident 2 out of the van to get on the lift and as she stepped over the alarming plate, the alarm did not sound to inform the Nurse Aide/Transporter 1 that the lift was down and not up. Nurse Aide/Transporter 1 and Resident 2 fell backwards before the lift was returned to the upper position from the previous transfer. Resident 2's head was in contact with the edge of the lift platform, and the mid upper occipital area was swelling and there was a small laceration. Resident 2 was sent to the local emergency room and was then transferred to another hospital after a subdural hematoma (bleeding in the brain) was noted. Hospital discharge records for Resident 2, dated June 30, 2024, revealed that she was seen for a fall and head injury. Resident 2 was seen and evaluated by the neurosurgery team for bleeding in the brain. Resident 2's coumadin (a blood thinner medication) needed to be reversed to help prevent the bleed from increasing. Resident 2 was started on Keppra (antiseizure medication) for seven days for prevention of seizures. Interview with Nurse Aide/Transporter 1 on June 26, 2024, at 2:45 p.m. confirmed that she was unaware that the other Nurse Aide/Transporter did not put the lift platform back to the up position. She did not look behind her, because she was focused pushing Resident 2 out of the van without hitting her arms on the sides of the lift. When she was going to push Resident 2 onto the lift platform, she stepped over the alarm plate and the alarm did not sound that the lift was not in the up position. However, Resident 2's momentum did not allow Nurse Aide/Transporter 1 to push the resident back into the van. Both fell from the van, and Resident 2 landed on top of Nurse Aide/Transporter 1 and hit her head. Interview with the Director of Nursing on July 10, 2024, at 12:42 p.m. confirmed that Nurse Aide/Transporter 1 did not ensure that the lift was in the up position when pushing Resident 2 out of the van, resulting in a fall with a head injury. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.