STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395718	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Heights	1400 Waverly Road Gladwyne, PA 19035

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 - Minimal harm or potential for 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** Based on review of clinical records, facility documentation, and staff interview, it was determined that the facility failed to ensure adequate assistance was provided during a transfer, resulting in a fall for one of three residents reviewed for falls (Resident R1). This was identified as past non-compliance.Findings include:Clinical record review revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses including atherosclerotic heart disease, polymyalgia rheumatica, and a history of falls.Review of Resident R1's care plan, dated October 10, 2023, indicated the resident was at risk for falls related to deconditioning. Further review of the care plan revealed that Resident R1 required a two-person assist for toileting and transfers.Review of the facility's investigation, dated March 30, 2026, revealed that Employee E1, Nurse Aide, attempted to transfer Resident R1 using a standing lift without assistance. During the transfer, the resident let go of the lift and their knees buckled. Employee E1 then called out to the resident's caregiver for assistance to help lower the resident to the floor.Review of Resident R1's private caregiver witness statement, dated March 24, 2026, revealed on March 24, 2026, The (nurse aide), transferred (Resident R1) from bed to bathroom used sit to stand lift by self she gave shower and dressed her. I was sitting in chair by window, (nurse aide) called for my help. I went to bathroom (Resident R1) was slipping out sit stand lift we lowered her to the floor. An interview on April 09, 2026 at 10:54 a.m. with Director of Nursing, Employee E2, confirmed that Resident R1 required a two-person assist at time of the transfer. Following the incident on March 24, 2026, the facility implemented the following corrective actions:On March 24, 2026, Resident R1's care plan was immediately updated to specify the use of two staff members for transfers via Hoyer lift. From March 24, 2026, through March 30, 2026, in-service training was provided to all nurse aides and nurses, with ongoing training continuing as needed. From March 24, 2026, through April 6, 2026, staff competencies for sit-to-stand mechanical lifts were completed for all nurse aides and nursesStarting March 2026 and April 2026 all care plan and care cue cards were audited for accuracy and will continue monthly for the next 12 months. Review of Resident R1's clinical record and cue card confirmed correct transfer status is in place. This deficiency was identified as past non-compliance. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (d)(5) Nursing Services.

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