STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395720	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Village, Inc	1800 Village Circle Lancaster, PA 17604

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 Note: The nursing home is disputing this citation.	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 clinical record review, resident interview, and staff interviews, it was determined the facility failed to ensure equipment was used in a safe manner, resulting in actual harm to one of eight residents reviewed (Resident R1). Specifically, the facility failed to ensure a Broda chair was positioned and operated safely during resident care, resulting in Resident R1 sliding out of the chair and sustaining a fracture.Findings include:Review of Resident R1's clinical record revealed the following diagnoses: Hemiplegia and Hemiparesis following non-traumatic intracerebral hemorrhage (muscle weakness or partial paralysis on one side of the body), Cerebral Infarction (stroke), Osteoarthritis (degenerative joint disease, causing pain, stiffness, and reduced mobility when protective cartilage wears down, causing bones to rub together), Type 2 Diabetes (chronic condition where the body develops insulin resistance and cannot use insulin effectively, leading to high blood sugar levels), Fibromyalgia (widespread pain and fatigue), and Macular Degeneration (loss of vision).Review of Resident R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.Review of Resident R1's Comprehensive care plan dated December 18, 2025, revealed Resident R1:Required substantial assistance for upper body dressingWas dependent on staff and required a Hoyer lift for all transfersWas non-ambulatoryRequired staff assistance for all mobility while seated in a Broda chairReview of information dated January 15, 2026, submitted to the Department of Health by the facility, revealed that on the evening of January 11, 2026, Resident R1 slid out of his/her Broda chair during evening care and sustained an injury. Review of Resident R1's nursing progress note dated January 11, 2026, at 8:06 p.m. revealed Certified Nursing Assistant (CNA) Employee E3 leaned Resident R1 forward to check the placement of the Hoyer lift sling, the resident slid forward and landed on the floor on (his/her) knees. The note further documented the seat of the Broda chair was tilted forward, with the front edge lower than the back edge, and was not parallel to the ground. Resident R1 was assisted back to bed using a Hoyer lift (mechanical device designed to assist in lifting and transferring individuals with limited mobility) and two nurses. The physician and family were notified.Review of Resident R1's clinical record revealed a Registered Nurse (RN) assessment completed immediately following the incident documenting the Broda chair seat was tilted forward and not parallel to the ground, creating an unsafe positioning during resident care.Review of nursing progress notes dated January 13, 2026, revealed the resident reported pain and bruising to the right lower extremity. Additional review of nursing progress notes indicated that Resident R1 was receiving routine Tylenol and Gabapentin for pain management. Review of Resident R1's clinical record revealed diagnostic imaging (X-RAY) performed on January 13, 2026 (9:20 a.m.) confirmed Resident R1 a recent fracture of the distal (lower) shaft of the right fibula (lower leg bone).Review of facility incident report dated January 11, 2026, included a written statement from Certified Nursing Assistant (CNA) Employee E3, indicating that while providing evening (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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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	care and leaning the resident forward to change (his/her) blouse, Resident R1 slid out of the Broda chair and onto (his/her) knees.Review of Resident R1's clinical record revealed Resident R1 was transported to a local hospital on January 13, 2026, for further evaluation and returned the same day at 9:15 p.m., with a plaster splint applied to the right foot/ankle.Additional review of the clinical record revealed a Physician order for Tramadol 50 mg (milligram) by mouth every eight hours as needed for pain for ten days with a start date of January 19, 2026.During an interview conducted with the Nursing Home Administrator (NHA) on February 2, 2026, at 9:27 a.m., the NHA reported that Resident R1 received a new Broda chair on January 12, 2026, and that the seat of the new chair does not tilt forward.The Nursing Home Administrator (NHA) provided a list of all residents currently using Broda chairs. Observations conducted of the Broda chairs used by Residents R2 through R8 revealed that all chairs had levers clearly labeled, indicating the top lever adjusted the back support and the bottom lever adjusted the seat tilt.During an interview conducted with Certified Nursing Assistant (CNA) Employee E4 on February 2, 2026, at 10:50 a.m., Employee E4 revealed the labels were placed on the Broda chairs following the incident involving Resident R1.During an interview conducted with Resident R1 on February 2, 2026, at 11:33 a.m., the resident stated (he/she) slid out of (his/her) Broda chair because the seat was tilted too far forward and reported experiencing significant pain as a result of the injury.During a phone interview conducted on February 2, 2026, at 11:48 a.m., non-licensed staff, Employee E3 confirmed that Resident R1 slid out of the Broda chair after Employee E3 tilted the seat too far forward. As a result of the fall, Resident R1 sustained a right ankle fracture.During an interview conducted with Occupational Therapist Employee E5 on February 2, 2026, at approximately 1:38 p.m., Employee E5 reported all nursing staff received one-on-one training on the safe operation of resident adaptive equipment, including Broda chairs.During an interview conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on February 2, 2026, at approximately 2:15 p.m., facility leadership confirmed the above findings.The facility failed to ensure Resident R1's Broda chair was positioned and operated in a safe manner during care, resulting in the resident sliding out of the chair and sustaining a right ankle fracture, constituting actual harm.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.