STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395774	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Nursing and Rehabilitation Center	900 East King Street Lancaster, PA 17602

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41765 Based on a review of the facility's policy, clinical records, and facility documentation, as well as staff interviews, it was determined that the facility failed to timely notify the physician of an unwitnessed fall with a facial bruise for one of 35 residents reviewed (Resident 305). Findings include: A review of the facility's policy titled Change in Resident's Condition or Status, with a revision date of February 2021, revealed that the facility promptly notifies the resident, attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been an: Accident or incident involving the resident; and need to alter the resident's medical treatment significantly. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. Clinical records review revealed Resident 305's diagnosis list includes Dementia (A term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), Anxiety, and Heart Failure. The clinical records also revealed Resident 305 was on Eliquis (An anticoagulant medication) for Afib (Atrial Fibrillation irregular, often rapid heart rate that commonly causes poor blood flow). A review of the nursing progress notes dated April 1, 2025, at 7:45 a.m., revealed Resident 305 had an unwitnessed fall in her/his room while attempting to toilet self. Injury details revealed right eye swollen, hematoma (A collection of blood outside of blood vessels, often within tissues, typically caused by injury). A review of the facility's documentation Incident Report, revealed that on April 1, 2025, at 7:20 a.m., the resident's roommate alerted the staff that Resident 305 had fallen. The resident was observed on the floor with their head at the end of the bed. The resident stated that she/he was attempting to go to the bathroom but fell and hit her/his right eye. The same report revealed that the Nurse Practitioner and the family were notified via VM (voicemail). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Nurse Practitioner's progress notes dated April 2, 2025, at 6:40 p.m., revealed that the patient was seen due to reports from therapy that the resident had a change in breathing status. The same note revealed that nursing reported that the resident had a fall yesterday which resulted in bruising over the right eye. The resident was assessed, and the order was made and followed. An interview with the Nurse Practitioner was conducted on April 10, 2025, at 1:38 p.m. The NP reported not being notified of the fall that occurred on the morning of April 1, 2025. The NP reported that she/he was notified of the April 1, 2025, fall on April 2, 2025, at around lunchtime after she/he observed the bruise on the resident's right eye during the visit. The NP reported that she/he would have ordered to hold the resident's Eliquis for a day if notified timely. An interview conducted with licensed nurse Employee E7 on April 11, 2025, at 9:05 a.m., revealed that she/he completed the fall incident report on April 1, 2025, and the one who notified the family and the NP of the fall with injury to the face. Employee E7 reported that she/he notified the NP [stated the name of the NP] on the day of the fall by sending the NP a text message via personal mobile phone but Employee E7 was unable to provide any evidence that the notification had occurred. Employee E7 stated, I thought I did. The above occurrence was conveyed to the NHA on April 11, 2025, at 10:00 a.m. The facility failed to timely notify the physician of Resident 305's unwitnessed fall with facial injury. 28 Pa Code 483.25 Quality of Care Previously cited 5/22/24 28 Pa. Code 201.18(b)(1) Management Previously cited 5/22/24 28 Pa. Code 211.5(f) Clinical records Previously cited 5/22/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 5/22/24

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 30934 Based on observation, interview with residents and staff, it was determined that the facility failed to ensure resident call bells were answered and addressed in an appropriate amount of time for one of one resident (Resident R197). Finds include: Review of Resident R197's clinical record revealed the following diagnoses: unspecified injury at an unspecified level of the cervical spinal cord (spinal cord injury), quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down), and muscle wasting and atrophy (thinning of muscle tissue). Review of Resident R197's care plan revealed the following interventions: TRANSFER: Resident is dependent on the assistance of two staff members using a mechanical lift (Hoyer lift) for all transfers; non-ambulatory. This care plan had a start date of March 4, 2019. An interview conducted with Resident R197 on April 8, 2025, at 9:45 a.m. revealed that when he activates his call bell (a system used to notify staff that assistance is required), staff will enter his room, turn off the call bell, and then leave without providing further assistance. Review of Resident R197's clinical record revealed a progress note dated April 1, 2025, at 3:01 p.m., which stated: Resident rang for assistance to get out of bed (OOB) four times, all within approximately 15-minute intervals. Resident was informed each time that the CNA assigned to provide care was also training a new CNA that day, so it would take her longer to complete her duties in order to ensure proper training. Resident was unhappy with this explanation. We will continue to communicate with the resident regarding their assignments and any changes to them. An interview conducted with the Nursing Home Administrator (NHA) on April 11, 2025, at 1:15 p.m. confirmed the above. 28 Pa. Code 211.12(d)(1(5) Nursing services