

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2025
NAME OF PROVIDER OR SUPPLIER Letort Spring Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. Hanover Street Carlisle, PA 17013	

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 0689</p> <p>Level of Harm - Minimal harm or potential for 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>Based on record review and staff interview, it was determined that the facility failed to prevent accident and hazards for one of 10 residents reviewed (Resident 2). Findings include: Review of Resident 2's clinical record revealed diagnoses that included dementia (a progressive cognitive and mental decline that is severe enough to interfere with daily life, affecting memory, thinking, language, and judgment) and hypertension (high blood pressure). Review of Resident 2's clinical record revealed a fall incident report where the resident had an unwitnessed fall on November 10, 2025, at 7:10 PM, onto the floor in the Love 2 Lounge and was found sitting in a semi-Fowler's position directly in front of her wheelchair. Further review of the incident report revealed there were no predisposing environmental factors noted during the fall. Further review of the fall incident report revealed an employee witness statement (Employee 1) revealed that Resident 2 went into the dayroom for dinner and was brought back to the dining room on Love and was last seen by Employee 1 at 5:45 PM at the dining room on Love. Review of Employee 2's witness statement from the fall incident report revealed that they last saw Resident 2 in the lounge after dinner during the day the incident occurred. Review of Employee 3's witness statement from the fall incident report revealed that they last saw Resident 2 at supper and was talking with a family when another staff member made them aware that Resident 2 had fallen. Review of Employee 4's witness statement from the fall incident report revealed that they were watching all the residents in Love 1 Lounge. Around 6:30 PM, a resident's daughter came in to visit and asked Employee 4 to take them to Love 2 Lounge and then came back and informed them Resident 2 was on the floor. Review of Resident 2's comprehensive care plan revealed a focus area that the Resident is at risk for falls, initiated on March 4, 2024, and an intervention to assist the Resident to her room after dinner to prevent falls, initiated on September 30, 2025. Review of the facility's dinner mealtimes revealed that the dining room is served dinner at 5:15 PM, Love 1 Lounge at 5:30 PM, Faith Lounge at 5:45 PM, and Love 2 Lounge at 6:00 PM. Review of the facility's fall incident report on Resident 2 on November 10, 2025, failed to reveal any staff witness statements that Resident 2 was still eating dinner at the time of the fall. Interview conducted with the Nursing Home Administrator and Director of Nursing on December 23, 2025, at 2:15 PM, revealed that, although it was not included in the employee statements, Resident 2 was still eating dinner at the time her fall occurred on November 10, 2025. 28 Pa. Code 201.18(b)(1)(2) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide adaptive feeding devices for one of 10 residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed diagnoses that included dementia (a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and heart failure (when the heart muscle doesn't pump blood as well as it should). Review of Resident 1's physician orders revealed an order to make sure the Resident has a water cup filled and food is being cut up at mealtimes, dated December 4, 2025, as well as an order for the Resident to have foam handled utensils for all meals, dated June 10, 2024. Review of Resident 1's care plan revealed a nutritional care plan focus area with an intervention to provide adaptive equipment as ordered, date initiated on May 22, 2024, and revised on April 1, 2025. Observation of Resident 1 on December 22, 2025, at approximately 12:15 PM, revealed he was eating lunch in the dining room and did not have foam handled utensils, and his food was not cut up. Further observation revealed another resident at the table (Resident 5) reached over and cut Resident 1's food up for him. Review of Resident 1's lunch tray ticket for December 22, 2025, revealed that it was noted on his ticket that he was to have foam handled utensils. During a staff interview with the Nursing Home Administrator (NHA) on December 23, 2025, at approximately 3:00 PM, the NHA confirmed that Resident 1 should have received his foam utensils during lunch and should have had staff cut his food up as ordered. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(2)(3)(5) Nursing services.</p>