

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Landis Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East Oregon Road Lititz, PA 17543	

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. (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record and facility documentation review it was determined the facility failed to ensure that one of 19 residents reviewed was free from accidents by failing to provide adequate supervision resulting in harm to Resident 11 who sustained a scalp laceration. Findings include: Review of Resident 11's diagnosis sheet revealed diagnoses Alzheimer's Disease (memory loss, cognitive decline, behavior changes), Vascular Dementia Severe with Mood Disturbances, Vascular Dementia Severe with Agitation, Vascular Dementia Severe with Psychotic Disturbance (group of conditions that cause a decline in cognitive function, including memory, thinking, reasoning, and problem solving, severe enough to interfere with daily life), and Lack of Coordination. Review of Resident 11's Care Plan revealed a care focus titled Hygiene Assistance with Activities of Daily Living (ADLs) indicating the resident has an ADL self-care performance deficit with bathing, dressing, and feeding related to vascular dementia and history of fractures requiring 2-person assistance with transfers, bed mobility, toileting, and bathing, initiated May 5, 2025. Review of Resident 11's Care Plan revealed a care focus titled the Resident is combative and resistive to care related to Dementia. Review of Resident 11's Quarterly Minimum Data Set (MDS-periodic assessment of resident needs), dated September 15, 2025, revealed Resident 11 was dependent on staff for transfers, showering or bathing. Review of Resident 11's Quarterly MDS dated [DATE], revealed the resident has a BIMS (brief interview for mental status) score of 0 indicating severe cognitive functioning. Review of Resident 11's progress notes revealed a nursing note dated September 13, 2025, at 7:38 a.m., indicating Resident 11 was sent out to hospital, 2 assisted to shower room this morning. Once shower started, resident increased behaviors, yelling and threw self out of shower chair. Hit head against wall. Seen laying on right side. 3 assisted up to wheelchair. Large laceration noted to top right head, measures 12x6 cm (centimeters) with flap of skin, unable to approximate. Pressure applied to stop bleeding with ice. Resident did not lose consciousness. Continue with combativeness and aggression. Bleeding noted to stop. Sent to ED (Hospital Emergency Department) at 7:30 a.m. POA (Power of Attorney-person legally authorized to make decisions on behalf of another person) updated per supervisor. Review of Resident 11's hospital discharge report, dated September 13, 2025, revealed a right scalp laceration requiring 26 staples. Review of information dated September 13, 2025 submitted to the state agency revealed Resident 11 fell out of a shower chair on Saturday, September 13, 2025, at 0730 (a.m.) and sustained a laceration with a flap to his/her scalp measuring 12 cm x 6 cm. Resident POA (Power of Attorney) and On-call MD (Medical Director) notified and sent to a Community Hospital for evaluation and sutures. Investigation initiated. Further review of information submitted to the Department on September 13, 2025, revealed under subheading titled Follow-up: staff statements obtained; and according to staff statements they transferred resident with 2-person assist to the shower chair and then took the resident to the spa room where Certified Nurse Aide Employee E4 proceeded to provide the resident with a shower. The resident was combative trying to hit and bite the employee, the employee handed the resident a washcloth in attempts to distract his/her attention, the resident lunged at the employee, causing the resident to fall out of the shower chair. Staff did not follow care plan to have 2 staff present for shower. Staff suspended pending further investigation, [NAME] County Office of Aging Notified. Education to entire team will be provided to follow plan of care, and to stop care if resident is agitated. The resident returned from the hospital with following report: CT (computed tomography) head and cervical spine negative for acute injury. No bleed. Tetanus immunization updated. Laceration repaired. Patient is stable for discharge and outpatient follow-up. Head injury precautions given. PB22 to follow. Resident's BIMs 00/15 Resident will be bed bath with 2-person assist. September 16, 2025, PB22s submitted. Review of facility investigation into the injury revealed a witness statement from certified nurse aide Employee E3, dated September 13, 2025, indicating Employee E3 and certified nurse aide Employee E4 both wheeled the resident into the shower room. Employee E3 then told Employee E4 to use the call bell if assistance was required then left the shower room. The call bell rang approximately two minutes later, when Employee E3 returned to the shower room the resident was noted as on the floor bleeding. Employee E5 was called in to assist with getting the resident back into the wheelchair. Review of facility investigation into the injury revealed a witness statement from Employee E4 indicating Employee E4 attempted to shower the resident alone, the resident was trying to bite and grab Employee E4. Employee E4 handed the resident a washcloth so the resident could assist with washing and divert the resident's attention. The resident lunged at</p>		