STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395802	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornwald Home	442 Walnut Bottom Road 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)
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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(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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a 10 cm (centimeter) x 8 cm x 1 cm laceration (a deep cut or tear in the skin) to the right leg, requiring 15 sutures (stitches), for one of seven residents reviewed (Resident 1). Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents, which resulted in actual harm as evidenced by a 10 cm (centimeter) x 8 cm x 1 cm laceration (a deep cut or tear in the skin) to the right leg, requiring 15 stitches, for one of seven residents reviewed (Resident 1). Findings include:Review of facility policy, titled No Lift Program, dated June 22, 2018, revealed The staff will do NO transfer, repositioning, or lifting without the aid of required and provided equipment.During an interview with the Nursing Home Administrator (NHA) on July 21, 2025, at 11:43 AM, she stated that all facility lifts require the assistance of two staff members. Review of Resident 1's clinical record revealed diagnoses that included stroke and hypertension (high blood pressure). Review of Resident 1's care plan revealed an intervention, dated March 24, 2025, to transfer with staff assist of two using stand aid. Review of Resident 1's Resident Care Guide, revealed an intervention on March 24, 2025, for two assist with stand aid for all transfers. Review of Resident 1's physical therapy Discharge summary, dated [DATE], revealed discharge recommendations for staff to use the stand aid lift with two person assist for transfers.Review of Resident 1's nursing progress notes revealed a note on July 4, 2025, stating that Resident 1 sustained a laceration (a deep cut or tear in the skin) to her right lower lateral (to the side of) leg during a transfer from her wheelchair to her bed at 6:10 PM. Upon assessment, the laceration was noted to be bleeding and measured 10 cm x 8 cm x 1 cm, with fatty layer exposed. Resident was transferred to the hospital for further treatment at 7:20 PM. Review of Resident 1's clinical record revealed that Resident 1 returned to the facility on July 4, 2025, at approximately 10:50 PM. Further review revealed that she received 15 sutures (stitches) to her right lower extremity laceration. Review of Resident 1's incident report, dated July 4, 2025, revealed that Employee 1 (Nurse Aide) assisted Resident 1 to bed, by herself, using a stand pivot from wheelchair. Further review of the incident report revealed that Employee 1 did not follow Resident 1's care plan for the transfer, which stated to use the stand aid with two assists. Review of facility's investigation revealed a statement from Employee 1, dated July 7, 2025. In the statement, Employee 1 stated that she transferred Resident 1 from her wheelchair to her bed, with a one assist stand pivot. After the transfer, Employee 1 noted that Resident 1 was bleeding, and she notified the supervisor. Further review of Employee 1's statement revealed that Employee 1 looked at Resident 1's care guide and saw she was a one assist for toileting. Employee 1 stated she was unaware of the need to scroll further on the care guide and failed to see that Resident 1 required the assist of two with a stand aid for transfers. During an interview with the NHA on July 21, 2025, at 2:42 PM, she stated that it is her expectation that staff follow a resident's correct transfer status. The facility failed to ensure that Resident 1 received adequate supervision and assistance to prevent accidents. Employee 1 failed to follow Resident 1's care planned transfer status and transferred Resident 1 via stand pivot, by herself. This resulted in a laceration to Resident 1's leg, requiring 15 sutures. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services