

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395802	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Thornwald Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that resident assessments accurately reflected the resident's status for three of 18 residents reviewed (Residents 4, 12, and 14). Findings include: Review of policy titled Bed Entrapment Prevention Program, revised November 11, 2022, read, in part, monitoring of resident's health status that may affect the risk of bed entrapment will be done periodically (at least quarterly) to assess resident continued need for the device and document in the electronic medical record. Review of facility policy, titled Trauma Informed Care, revised October 2024, read, in part, trauma informed care shall be an integral part of a person-centered environment. This involves an interdisciplinary approach to care. Ensuring care and services are person-centered and reflect the resident's goal for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety. Review of Resident 4's clinical record revealed diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system) and weakness (decrease or loss of muscle strength). During an interview with Resident 4 on December 8, 2025, at 10:32 AM, an observation of a right sided enabler bar was made. Resident 4 reported he used the bar to help him move while in bed. Review of Resident 4's physician orders revealed an order for right side bed enablers. Review of Resident 4's quarterly minimum data sets (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) dated August 18, 2025, and October 28, 2025, revealed Resident 4 was coded for restraint use related to enabler bars. An interview with the Nursing Home Administrator (NHA) on December 9, 2025, at 11:15 AM, revealed that Resident 4's MDSs had been coded incorrectly, and a modification would be done to correct them. During an additional interview with the NHA on December 10, 2025, at 10:35 AM, the NHA stated that it was the expectation of the facility that MDSs accurately reflect the Resident's status. Review of Resident 12's clinical record revealed diagnoses that included adjustment disorder with mixed anxiety and depressed mood. Interview with Resident 12 on December 8, 2025, at 11:50 AM, revealed that she had lost her son a year ago, and that was something she would never get over. Resident 12's care plan included a focus area for trauma informed care. The care plan indicated that Resident 12 witnessed someone choke and the heimlich was not successful. Resident chooses not to go to the dining room due to this experience, and services for counseling as indicated. Per Psychology consults dated September 22nd, 2025, and November 10th, 2025, it was documented that 50 percent of the session was related to grief/loss. Review of Resident 12's quarterly MDS dated [DATE], section I (diagnoses) failed to document PTSD (post-traumatic stress disorder - a mental health condition triggered by experiencing or witnessing a traumatic event). Interview with NHA on December 9, 2025, at 11:15 AM, it was revealed that Resident 12's November 7th, 2025, MDS should've documented PTSD and that the CMS form 802 (Matrix) was updated to include the PTSD/trauma informed care designation. Review of Resident 14's clinical record documented diagnoses that included hemiplegia (paralysis or severe weakness affecting one side of the body). Observation in Resident 14's room on December 10, 2025, at 11:30 AM, revealed an enabler bar was on the right side of the bed. Resident 14's physician orders included a right-side enabler for bed mobility (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395802	If continuation sheet Page 1 of 6

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and increased independence, start date August 14, 2025. Resident 14's quarterly MDS dated [DATE], revealed Resident 14's MDS was coded for restraint use related to enabler bars. Interview with NHA on December 9, 2025, at 11:30 AM, revealed that Resident 14's September 12th, 2025, MDS had been coded incorrectly, and a modification would be done to correct it. 28 Pa. Code 211.5(f) Clinical records28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on facility policy review, personnel file review, and staff interviews, it was determined that the facility failed to ensure that residents were protected from the potential for abuse by failing to verify the standing of professional license prior to hire for two of five personnel files reviewed (Employees 3 and 4). Findings Include: Review of facility policy, titled Admin Freedom from Abuse Policy, read, in part: I. Screening A. To ensure resident safety, UCC Homes will not hire prospective employees with disciplinary action against their licenses or certification, which includes Individuals found guilty of abuse. Prospective employees will undergo screening within the allowable timeframes. The screening process shall include: Verification of active Licensure or Certification with the Department of State and the original display portion of licenses on file, if applicable. Verification of enrollment in Department of State registry, if applicable. Review of the personnel file for Employee 3 (Certified Nursing Assistant [CNA]), revealed Employee 3's nursing assistant certification was verified on December 9, 2025, indicating certification verification was not completed prior to Employee 3's date of hire on September 10, 2025. Review of the personnel file for Employee 4 (Licensed Practical Nurse [LPN]), revealed license verification with the Pennsylvania licensing board was completed on December 9, 2025, indicating license verification was not completed prior to Employee 4's date of hire on November 19, 2025. During an interview with the Nursing Home Administration on December 11, 2025 at 8:30 AM, it was revealed that Human Resources completes a check list to ensure all items are completed, to include verification of license, and the information is forwarded to the hiring manager. The hiring manager discards the information that is not entered into the employee's file. They were unable to locate verification of licensure verification completed prior to the hire dates for Employee 3 and Employee 4. 28 Pa Code 201.18(e)(1)(2) Management 28 Pa Code 201.19 Personnel policy and procedures		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of one resident reviewed for pressure ulcers (Resident 10). Findings include: Review of facility policy, titled Wound Management Program Infection Prevention and Control, dated February 2018, revealed, in part, Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. The goal for a resident with a wound is one of promoting healing and preventing infection unless their preference and medical condition necessitate palliative care as the primary focus. Our facility's commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, evidence clinical guidelines, and interdisciplinary involvement. Review of facility policy, titled Skin Integrity Program: Pressure Ulcer Prevention/Treatment Program, dated April 27, 2023, revealed, in part, Based on a comprehensive assessment, the facility shall ensure that a resident who enters the facility without a pressure ulcer does not develop pressure ulcers unless the clinical condition demonstrates that they were unavoidable or if a pressure ulcer is present (e.g. time of admission) receives necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Revision of the interdisciplinary plan of care shall be based on the effectiveness of the interventions. Review of Resident 10's clinical record revealed diagnoses that included pressure ulcers (area of damaged skin and tissue caused by sustained pressure which reduces blood flow to the area) on the right heel, right buttock, and left heel; type II diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but may not require the use of insulin); and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Observations of Resident 10 on December 8, 2025, at 11:45 AM, and December 9, 2025, at 12:25 PM, revealed that he was up in his wheelchair in his room. He was noted to have an air overlay mattress on his bed, but the pump was off. Observation of Resident 10's room on December 10, 2025, at 1:53 PM, revealed that his air overlay mattress pump was off. Observation of Resident 10 on December 11, 2025, at 8:38 AM, with Employee 1 (Registered Nurse) and Employee 2 (Assistant Director of Nursing) revealed the Resident was in bed. The air overlay mattress pump was turned off and the connecting air hose on the overlay mattress was not connected to the pump. The connecting hose was noted to be on the floor at the foot of the bed. In addition, the pump was set to the setting for a Resident weight of 300 pounds. Employee 1 attempted to connect the hose to the pump, but the hose would not remain latched because the securing clip was broken off. Employee 2 pressed the power switch, but the pump did not come on. Employee 2 then checked to see if the cord was plugged in to the power source. Employee 2 indicated it was plugged in. Surveyor pressed the power switch, and the pump came on and then shut off. Employee 2 again checked the cord, and the pump came on and stayed on. Employee 2 indicated that she would contact maintenance to evaluate the electrical outlet and the air overlay mattress. Review of Resident 10's clinical record revealed that he weighed 159.2 pounds on December 1, 2025. Review of Resident 10's physician orders revealed an order for wound consult services for skin/wound conditions/prevention as needed, dated August 12, 2025. Review of Resident 10's clinical record revealed that he had been seen weekly by the wound consultant weekly since October 1, 2025. Further review of Resident 10's clinical record revealed the following: 1) the pressure ulcer to his right heel developed at the facility on September 22, 2025, and was currently classified as a unstageable (pressure ulcer where depth cannot be determined due to presence of necrotic tissue called eschar); 2) the pressure ulcer to his right buttock developed at the facility on October 31, 2025, and was currently classified as an unstageable; and 3) the pressure ulcer to his left heel developed at the facility on November 4, 2025, and was currently classified as a Stage 3 (pressure ulcer characterized by full-thickness skin loss, exposing the fatty tissue beneath, and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may present with slough-a moist yellowish colored dead tissue- or eschar, but does not expose bone or muscle). Review of Resident 10's wound consult note dated November 5, 2025, revealed that Resident 10 had developed two new pressure ulcers and indicated in the Assessment/Plan section of the note that he would benefit from an air mattress for additional pressure relief. Review of Resident 10's wound consult note dated November 12, 2025, revealed that the unstageable right heel ulcer was worsening; the right buttock unstageable ulcer was stable; and the left heel Stage 3 was stable. The Assessment/Plan section of the note again indicated would benefit from an air mattress for additional pressure relief. Review of Resident 10's wound consult note dated November 19, 2025, revealed that the unstageable right heel ulcer was improving without complications; the right buttock unstageable wound was stable; and the left heel stage 3 was worsening. The Assessment/Plan section of the note again indicated would benefit from an air mattress for additional pressure relief. Review of Resident 10's wound consult note dated November 26, 2025, revealed that the unstageable right heel ulcer was improving without complications; the right buttock unstageable wound was now classified as a Stage 3 and was stable; and the left heel stage 3 was stable. The Assessment/Plan section of the note again indicated would benefit from an air mattress for additional pressure relief. During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on December 10, 2025, at 3:05 PM, the NHA indicated that the air overlay mattress was placed on Resident 10's bed on November 21, 2025. Further review of Resident 10's clinical record failed to reveal a physician's order for an air overlay mattress or any documentation to support that the air overlay mattress was in place and the function/settings were being monitored between November 21, 2025, and December 10, 2025. During a staff interview with the NHA and Employee 2 on December 11, 2025, at 11:10 AM, Employee 2 indicated that maintenance had located the broken piece to the air hose under Resident 10's bed. She further indicated that maintenance replaced the air overlay mattress. The NHA confirmed that the pump should have been set for Resident 10's weight and that there were no orders prior today in place for staff to monitor the functioning or setting of Resident 10's air overlay mattress. The NHA confirmed that these measures should have been implemented when the air overlay mattress was initially placed on Resident 10's bed. She also added that they implemented education with staff about adding the monitoring of the air mattresses when they are ordered. During a staff interview with the NHA, DON, and Employee 2 on December 11, 2025, at 1:12 PM, the DON indicated that she had no documentation to provide to show why there was a three-week delay in applying the recommended air mattress on Resident 10's bed. She further indicated that she recalls that the interdisciplinary team had discussed Resident 10 in meetings in regard to the concern for the use of the air mattress and his high fall risk but could not provide supporting documentation of such. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, facility documentation, and staff interviews, it was determined that the facility failed to conduct regular inspection of all bed rails/enabler bars as part of a regular maintenance program to identify areas of possible entrapment for one of two residents reviewed with enabler bars (Resident 14). Findings include: Review of Resident 14's clinical record documented diagnoses that included hemiplegia (paralysis or severe weakness affecting one side of the body). Observation in Resident 14's room on December 10, 2025, at 11:30 AM, revealed an enabler bar was on the right side of the bed. Resident 14's physician orders included a right-side enabler for bed mobility and increased independence, start date August 14, 2025. Review of Resident 14's enabler bar assessment and consent for use of the enabler bar were signed August 14, 2025. Review of maintenance record for Resident 14's enabler bar (safety measurements) was dated April 10, 2025. Interview with the Nursing Home Administrator (NHA) on December 10, 2025, at 1:13 PM, it was revealed that assessment for use of enabler bars should be completed at minimum quarterly with the Minimum Data Set review (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) and the safety measurements are completed annually. Per Director Of Nursing on December 10, 2025, at 2:00 PM, it was revealed that Resident 14 had enablers placed on her bed in April 2025, and she requested they be removed due to not being able to see the cats, so they were removed. Then the Resident asked for the enablers to be placed back on her bed in August 2025. During an interview with the NHA on December 11, 2025, at 10:20 AM, it was revealed the enabler bars weren't measured when they were placed back on the bed in August 2025, and measurements should've been completed at that time. 28 Pa. Code 201.18 Management 28 Pa. Code 205.71 Bed and furnishing		