STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395824	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Center for Nursing	600 School House Road Danville, PA 17821

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, staff interviews, review of clinical records, and the census of the designated Hospice Specialty Unit, it was determined the facility failed to ensure sufficient and appropriately deployed nursing staff to consistently provide timely quality of care, supervision, and services necessary to meet the physical and mental well-being of 10 residents receiving hospice services. Findings include: Review of facility census revealed 10 residents currently receiving Hospice services in the designated Hospice Specialty Unit. The unit was staffed with one LPN (licensed practical nurse) and one nurse aide. Observation of the Hospice Unit on May 7, 2025, at 11:35 AM revealed six residents seated in the common area in wheelchairs and/or specialty chairs. The assigned LPN was stationed at the medication cart. Interview with Employee 1 (LPN) at the time of observation confirmed there was no other staff present as the assigned nurse aide was off unit on a scheduled break. During continued observation, two separate call bell lights were observed activated in resident rooms. Employee 1 responded to one call bell, leaving the common area unattended. While in the resident's room, Resident 8, seated in the common area and identified by the facility as a fall risk with poor safety awareness, was observed attempting to stand unassisted from her wheelchair, activating her chair alarm. Upon hearing the chair alarm, Employee 1 left the private resident room and rushed into the common area to address the sounding alarm. No staff member was present to supervise the common area while Employee 1 was answering call bells and attending to other residents' needs. Interview with Employee 1 on May 7, 2025, at 11:45 AM revealed that when a staff member takes a scheduled break, there is no assigned staff member to relieve and/or replace that staff member during their break, leaving the unit with only one staff member to care for all 10 residents. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued interview with Employee 1 revealed that the Hospice unit is not adequately staffed to meet the acuity of needs of the residents (a measure of the level of care someone needs, considering factors like the severity of their illness, the frequency of interventions required and potential for complications). Three out of the ten hospice residents use a mechanical lift (a lift that uses hydraulic power to transfer a person while cradled in a sling. Requiring the use of two staff members to operate.) for transfers, seven residents require two staff member assistance for bed mobility, transfers, and assist with cares, and seven require total staff assistance for feeding. Employee 1 stated that when the nurse and the nurse aide are providing care to resident who requires 2 staff assistance such as for transfers, toileting or bed mobility, the other residents in the common area are left unsupervised. There have been times when a bed or chair alarm are sounding but no one is available to check on the situation of the alarm as 2 staff members are tending to another resident's needs. Review of the Hospice unit information provided by the facility identified seven out of the ten residents required assistance with feeding and were unable to safely consume their meals without staff assistance. Continued observations of the common area on May 7, 2025, at approximately 12:20 PM revealed the meal trays were delivered on open carts to the Hospice unit. Six residents were seated together at the dining table. Five of the six residents seated at the table required staff assistance. Employee 1 and the Director of Nursing were the only two staff members present to assist with feeding the five dependent residents in the dining room. The nurse aide was providing feeding assistance to a dependent resident who preferred to eat in his room. One additional resident, who preferred to eat in her room, was required to wait until a staff member was available. Observation at 2:45 PM showed Resident 9 attempting to stand from a recliner chair unassisted, and Resident 8 again attempting to stand from her wheelchair. Both are identified fall risks. The Hospice unit census reflected that 9 out of 10 residents are considered fall risks. Interview with Employee 2 (LPN) on May 7, 2025, at 2:55 PM revealed that on May 6, 2025, during second shift, Employee 2 attempted to obtain assistance from staff on the 200 unit (unit adjacent to the Hospice unit) however no staff were available. She reported that it is not uncommon that the 200 unit cannot spare an employee to assist with the Hospice unit. Interview with Employee 3 on May 7, 2025, at 3:00 PM revealed that on May 4, 2025, during the second shift, the LPN called off and the facility did not provide an LPN for the Hospice unit. There was only one employee, a nurse aide, assigned to care for the entire Hospice unit. The LPN from the 200 unit was required to work the 200 unit and the Hospice unit. Employee 3 reported that the LPN was too busy performing the medication and treatment management for residents on both the 200 unit and the Hospice unit that Employee 3 was not provided with a second team member to assist with care. She reported it was difficult to manage the entire unit when many residents required the assistance of two staff members for safe transfers and bed mobility. Further interview with Employee 2 at 3:05 PM revealed that inadequate staffing during critical periods, such as when a resident is actively dying, prevents the nurse from offering necessary emotional support to grieving families, as the nurse is also responsible for routine cares, repositioning, and responding to call bells. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator and Director of Nursing on May 7, 2025, at approximately 3:30 PM confirmed the facility failed to account for resident acuity in determining adequate staffing and acknowledged that current staffing levels on the Hospice unit are insufficient to meet the needs of the resident population. 28 Pa. Code 201.18(b)(1)(e)(1)(2)(3)(6) Management 28 Pa. Code 211.12(c)(d)(1)(3)(4)(5) Nursing services