

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Emmanuel Center for Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on a review of clinical records, facility policies, facility-provided investigative documentation, and staff interviews, it was determined the facility failed to protect one of five residents reviewed (Resident 5) from abuse and neglect by not implementing the individualized care plan intervention requiring two staff members for bed mobility assistance, resulting in actual harm in the form of a spiral fracture of the distal left femur. This deficiency is cited as past noncompliance. Findings include: A review of the facility policy titled Freedom from Abuse, Neglect and Exploitation last reviewed by the facility in December 2025, revealed the facility will take appropriate steps to prevent occurrence of abuse, neglect, and misappropriation of resident property. All allegations are treated seriously, reported promptly and investigated thoroughly, and addressed with appropriate corrective or disciplinary action based on the findings, severity, circumstances, and regulatory requirements. The policy defines neglect as the failure of the facility, its team members, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A review of Resident 5's clinical record revealed admission to the facility on May 4, 2022, with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the dominant right side. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 16, 2026, revealed that Resident 5 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates intact cognition). The assessment revealed the resident required total staff assistance for self-care activities, bed mobility, and transfers. Review of the resident's plan of care dated September 15, 2022, indicated that Resident 5 had an ADL self-care performance deficit related to bed mobility with prescribed interventions that included the use of bilateral bed enabler bars (assistive devices attached to both sides of the bed to help support movement and positioning) and the assistance of two staff members for bed mobility. A review of Resident 5's Documentation Survey Report for May 2026, reflected staff completion of resident care tasks, also identified that the resident required assistance from two staff members for bed mobility. Nursing documentation dated May 19, 2026, at 1:39 PM revealed Employee 1, Nurse Aide, reported to the nurse that while rolling Resident 5 to change her, Employee 1 heard a crack in the resident's left hip area, and the resident immediately complained of pain. Nursing documentation dated May 19, 2026, at 1:43 PM indicated an x-ray was completed by a mobile x-ray service, which determined the resident had a fracture of the left distal femur (break in the thigh bone). The physician and nurse practitioner were notified and ordered the facility to send Resident 5 to the hospital emergency department for evaluation and treatment. Review of the x-ray report dated May 19, 2026, revealed Resident 5 sustained a mildly separated, slightly displaced acute spiral fracture (a twisting break in the thigh bone located just above the knee joint) of the distal left femur, indicating a corkscrew pattern break near the knee, with slight misalignment of the broken ends. A review of the facility's abuse and neglect investigation (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 0600 Level of Harm - Actual harm Residents Affected - Few	dated May 19, 2026, revealed Employee 1, Nurse Aide, and Employee 2, Nurse Aide, transferred Resident 5 back to bed utilizing a mechanical lift (a device used to safely transfer residents who require extensive physical assistance). Following the transfer, Employee 2 left the room. Employee 1 remained alone with the resident and continued care. While turning the resident in bed, Employee 1 heard a cracking or popping sound and the resident stated Oh, that felt good. The resident then reported pain in her left hip area. A review of a written statement completed by Employee 1 dated May 19, 2026, (no time indicated) revealed Employee 1 and Employee 2 transferred the resident to bed using the mechanical lift. After Employee 2 left the room, Employee 1 removed the resident's pants and rolled the resident onto her right side to provide incontinence care. During the turn, Employee 1 reported hearing a horrible popping sound. A review of a written statement completed by Employee 2 dated May 19, 2026, at 4:44 PM revealed Employee 2 assisted with transferring the resident into bed utilizing the mechanical lift and then left the room. Employee 2 documented that Employee 1 took care of rolling her and providing incontinence care independently. Review of the facility's abuse and neglect investigation revealed Employee 1 did not follow the resident's care plan intervention requiring assistance from two staff members for bed mobility. The facility concluded Employee 1 provided care alone despite the resident's identified need for two-person assistance. The facility's investigation substantiated caregiver neglect and determined the failure to follow the resident's care plan resulted in the resident sustaining the left femur fracture. Employee 1 was suspended during the investigation and subsequently terminated following substantiation of neglect. During an interview on June 10, 2026, at 11:45 AM the Nursing Home Administrator acknowledged Employee 1 failed to follow Resident 5's care plan requirement for two-person assistance with bed mobility. The Nursing Home Administrator further acknowledged the facility's investigation determined this failure resulted in the resident sustaining the left femur fracture and confirmed Employee 1's employment was terminated. The facility's failure to ensure staff implemented Resident 5's care plan intervention requiring two-person assistance for bed mobility resulted in actual harm when the resident sustained a spiral fracture of the distal left femur requiring diagnostic evaluation and hospital transfer. Therefore, the deficient practice constituted neglect and resulted in actual harm. Corrective actions implemented by the facility included: Upon Resident 5's return from the hospital, an assessment will be conducted, and the care plan updated accordingly. The bed mobility status for all residents will be reviewed with input from direct care staff. All residents with a questionable status will be reviewed by therapy. Nursing staff will undergo education regarding the importance of adhering to care plan and the facility's abuse policy. An audit will be conducted on all residents to ensure bed mobility is care planned accurately. The Director of Nursing or designee will perform weekly bed mobility audits once a week for 4 weeks, then monthly for 3 months, and report the findings to the Quality Assurance and Performance Improvement committee. The facility alleged, and survey findings supported, that substantial compliance was achieved on June 8, 2026. Therefore, this deficiency is cited as past noncompliance. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.		