STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395880	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoebe Berks	1 Heidelberg Drive Wernersville, PA 19565

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36935 Based on clinical record review, review of facility documentation, resident interview, and staff interview, it was determined that the facility failed to thoroughly investigate a fall for one of four sampled residents identified at risk for falls. (Resident 1) Findings include: Clinical record review revealed that Resident 1 was admitted to the facility with diagnoses that included congestive heart failure and osteoporosis. Review of the current care plan revealed that Resident 1 was at risk to fall due to muscle weakness and needed staff assistance for activities of daily living, including dressing and incontinence care. Review of the Minimum Data Set assessment completed on November 9, 2023, indicated that Resident 1 did not have impaired cognition. On January 11, 2024, a nurse (RN 1) noted that she was walking by the resident's room and saw Resident 1 sitting on the floor with her left lower leg extended behind her. RN 1 noted a nurse aide (NA 1) who was in the room stated that, She didn't fall. She just lowered to the ground. She wanted me to hold her up and I said that she needs to stand. I can't stand here and hold her up. Review of facility documentation revealed that Resident 1 stated, I told that girl I needed help to stand and she didn't help me. I can't stand on my own. I'm too weak and needed help. A statement from NA 1 on January 11, 2024, indicated that she came to change the resident at 7:00 a.m. and that she put the recliner chair up to help Resident 1 stand with her walker in front of her. NA 1 was trying to clean the resident and change her incontinence pad. She got the resident's brief and the resident slipped on the floor. She asked me to hold her but she was already on the floor. An interdisciplinary team fall review note dated January 12, 2024, stated that the resident was assisted to stand using a walker and lifting of a recliner chair. The NA attempted to provide incontinence care to Resident 1 at that time. Resident 1's left leg slipped out from under her and staff attempted to assist Resident 1 to the ground. Further review of facility documentation revealed that a statement was obtained from NA 2 on January 11, 2024. NA 2 stated that she heard RN 1 ask Resident 1 if she fell and then entered Resident 1's room. Resident 1 was on the floor and her left leg was in a weird position. NA 1 was in Resident 1's room. When NA 1 left the room, Resident 1 told NA 2 that NA 1 let her fall. Resident 1 told NA 2 that NA 1 was trying to change her while she was standing and that she told NA 1 that she could not stand any longer. NA 1 wasn't supporting her and did not have a hand on her. (continued on next page)

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 - Minimal harm or potential for actual harm Residents Affected - Few	Another statement from NA 1 was obtained on January 12, 2024. She stated that Resident 1 was sitting in her recliner chair and she brought it higher to make it easier for her to stand with her walker in front of her. At the same time, RN 1 came in the room and NA 1 asked RN 1 if she could assist her in changing Resident 1's incontinence pad. She stated RN 1 turned and walked away so she turned away quickly to grab a washcloth and as she was grabbing the washcloth, she saw Resident 1's right leg giving out and before she knew it, she was on the ground. She stated she was holding Resident 1 the entire time and that she never refused to hold her up. In an interview on January 25, 2024, at 1:00 p.m., Resident 1 stated that during the incident NA 1 did not assist her or touch her prior to her fall and that she had told NA she was weak and could not stand. Further review of facility documentation revealed that interventions implemented after the fall were a call don't fall sign by Resident 1's recliner and in her bathroom to remind her to call for help during the night when she needs to transfer or ambulate. There was no documented evidence that the facility thoroughly investigated the reported inconsistencies in order to determine the circumstances of Resident 1's fall and implement appropriate interventions. 28 Pa. Code 211.12(d)(5) Nursing services.