STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395922	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artman Lutheran Home	250 North Bethlehem Pike Ambler, PA 19002

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interviews and the review of facility documentation, it was determined that the facility failed to ensure a complete and through investigation for resident who sustained a fractured hip (Resident R37) for 1 out of 14 residents reviewed. (Resident R37) Findings include: Review of an incident dated March 14, 2026, submitted to the State Survey Agency reported that the resident's nurse aide found the resident sitting on the toilet in the bathroom located in (his/her) room, with (his/her) companion on the 7:00 a.m. through the 3:00 p.m. nursing shift. The reportable incident stated that the resident's companion reported that the resident fell off the toilet and she (the companion, Employee E8) picked the resident up and put him back on the toilet. The reportable event stated that the resident had severe cognitive impairment, non- ambulatory and needed the maximum assist of 2 people for transfers. According to the reportable event, the resident was assisted onto the toilet around 10:00 a.m. by his nurse aide and the nursing supervisor and was left on the toilet with his companion who was instructed to ring the call bell when he was ready to get up. Continued review of the reportable event indicated that the companion stated that she was standing outside of the bathroom when she saw the resident stand quickly and fall to the floor. The reportable incident indicated that the companion stated that she could not get to the resident in time to prevent the fall. Continued review of the reportable event indicated that the resident complained of hip pain, an x-ray was obtained at the facility and the results of the x-ray showed that the resident sustained an acute left femoral intertrochanteric fracture (left hip fracture). The reportable event stated that the resident was sent to the hospital emergency room for treatment. Review of a witness statement dated March 14, 2026, regarding the above-referenced incident from Employee E4 (nurse aide) stated that the nurse aide reported that both she and the licensed nurse (Employee E10) put the resident on the toilet and informed the companion to ring the call bell when the resident was finished. Continued review of the resident's statement indicated that the nurse aide walked in the bathroom and found the resident sitting on the toilet. Nurse aide reported that the companion told her that the resident fell and then she told the nurse. During an interview with the nurse aide, Employee E4 on April 30, 3036 at 1:08 p.m. the nurse aide reported that both she and the licensed nurse supervisor (Employee E10) put the resident on the toilet and that (he/she) fell off the toilet when (he/she) was left with the companion. The nurse aide reported that the companion was standing in the doorway of the bathroom after she and the license nurse put the resident on the toilet in the bathroom. Nurse aide reported that the companion told her that she took the resident off the floor and put him back on the toilet. Nurse aide reported that she told another nurse (Employee E9) what the companion had just told her about the resident falling off the toilet and the companion reporting that she picked the resident up from the floor and put him back onto the toilet. During an interview with licensed nurse (Employee E9) on April 30, 2026 at 1:34 p.m. licensed nurse reported that she the nurse aide (Employee E4) notified her that the resident fell off the toilet and that the resident's companion picked him put off the floor and put him back on the toilet so that he could finish using the bathroom. Licensed nurse, Employee E9 reported that she notified the nurse supervisor (Employee E10). Licensed nurse, Employee E9 reported that when she walked in the resident's room after the nurse aide called her in, the resident was sitting in his wheelchair next to the table in his room facing the door. Review of the facility's (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation did include a written statement from licensed nurse (Employee E9). Review of the facility's interview with the nurse aide (Employee E4) did not reveal a statement from her indicating that she had the companion assist her with transferring the resident from the toilet back to his wheelchair in his room. During a 2nd interview with the nurse aide (Employee E4) on April 30, 2026, at 1:45 p.m. the nurse aide reported that the resident was on the toilet when she went back into the bathroom to answer the call bell, and that both she and the companion transferred the resident from the toilet to his wheelchair. Review of a written statement from nursing supervisor (Employee E10) dated March 14, 2026, nursing supervisor reported that she assisted the nurse aide (Employee E4) with transferring the resident to the toilet. Nursing supervisor's reported in her statement that she instructed the resident's companion to ring the call bell when the resident was finished using the bathroomDuring an interview with nursing supervisor on April 10, 2026 at 1:47 p.m. nursing supervisor reported that she helped the nurse aide transfer the resident to the bathroom toilet located in the resident's room. Nursing aide reported that the companion was sitting on the chair across from the resident outside of the bathroom in his room when they left the room. Nursing supervisor reported that she instructed the companion to pull the call bell in his room when the resident was finished using the bathroom. Nursing supervisor reported that licensed nurse (Employee E9) came to her and informed her that the resident fell off the toilet and that the companion picked him up. Nurse supervisor reported that she went to the resident's room and he was sitting in his wheelchair. Nurse supervisor reported that she spoke with the companion and was notified by the companion that the resident stood up from the toilet and by the time she got to him he fell on the bathroom floor. Nurse supervisor reported that she was pretty sure that the nurse aide (Employee E4) and the companion transferred the resident from the toilet to the chair. Nursing supervisor reported that residents require two staff members for transfers and that companions are not allowed to assist staff with transferring a resident in the facility. Review of a written statement from the resident's companion (Employee E8) indicated that the companion stated that the resident was on the toilet and that she was waiting outside the bathroom when she saw him quickly stand. The companion reported in her statement that she tried to go towards him but the resident fell before she could get to him. Continued review of the companion's statement indicated that she picked him up from off the floor and sat him back on the toilet. During an interview with the companion on May 11, 2026, at 1:20 p.m. the companion reported that she works as a paid companion from an agency from 7:00 a.m. through 7:00 p.m. every other Saturday and reported that she is not allowed to provide care to or transfer residents. Continued interview with the companion regarding the incident on March 14, 2025 indicated that the resident was transferred to the toilet by two staff members at the facility and that she stood outside the bathroom door with the door open, to provide the resident with privacy. The companion reported that the resident stood up so quickly that she could not do anything about it. She reported that she ran to him as soon as she saw him stand. Companion reported that the resident then fell, and then picked him up from the bathroom floor and pulled the call bell in the bathroom for help. Companion reported that she did assist the nurse aide (Employee E4) with transferring the resident to his wheelchair once the nurse aide came in. Review of the facility's interview with the companion (Employee E8) did not reveal a statement from her indicating that she assisted the nurse aide (Employee E4) with transferring the resident from the toilet back to his wheelchair in his room. 28 Pa. Code 211.12(c)(d)(1) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations and the review of clinical records it was determined that the facility failed to acknowledge a physician recommendation regarding a resident's positioning during meal times for 1 out of 14 residents reviewed (Resident R37).Findings include: Review of the April 2026 physician orders for Resident R37 included the following diagnoses of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life); arthritis (the swelling and tenderness of one or more joints); macular degeneration (age related eye condition in which individuals cannot see things directly in front of them); difficulty walking; contracture of left hand, and fracture of unspecified part of neck of left femur and dysphagia (difficulty swallowing). Review of the resident's Comprehensive Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated December 18, 202,5 indicated that the resident was cognitively impaired. During an observation on April 29, 2026, at 12:30 p.m. the resident was observed eating lunch in (his/her) room in the bed with his companion present. Review of a note from nurse practitioner (Employee E11) dated April 14, 2026, at 1:00 p.m. stated that the resident was seen on the above referenced date with concerns from the resident's daughter that the resident had a coughing fit that last for over an hour. Continued review of the nursing note indicated that since the above referenced incident that the daughter described, the note documented that the resident continued to have an occasional moist, non-productive cough, and that this is chronic for the resident due to the resident's poor posture and difficulty in swallowing. Continued review of the above referenced documentation from the nurse practitioner documented that the resident was being fed lying in his bed. The nurse practitioner recommended for the resident to have all of his meals out of bed in his chair to reduce the risk of aspiration (occurs when something that's supposed to be in an individual's stomach - like food, water or gastric acid - or anything that isn't air gets into your airways which can lead to complications like airway blockage and infections). Review of the resident's April 2026 and May 2026 physician orders did not show evidence that the nurse practitioner's recommendations were acknowledged by the facility. During an interview with the nurse practitioner on April 30, 2026, at 1:00 p.m. the nurse practitioner reported that the family and the facility were both concerned about coughing and she was contacted by the facility to assess the resident. She reported that she made the above referred recommendation after her assessment to have the resident eat out of bed to the nursing staff. 28 Pa. Code 211.10(c)(d) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and the review of clinical documentation, it was determined the facility failed to ensure that a resident received supervision during toileting and was transferred by facility staff members after sustaining a fall incident in the bathroom for one of 14 residents reviewed. (Resident R37)Findings include: Review of Companion Services/Private Caregivers policy with a revision date of July 26, 2018, revealed it is the policy of the facility to obtain documentation of services to be provided by a companion or private caregiver from the resident representative or employer. Review of Resident R37's clinical record revealed April 2026 physician orders including the following diagnoses: Dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life); Arthritis (swelling and tenderness of one or more joints); Macular Degeneration (age related eye condition in which individuals cannot see things directly in front of them); Dysphagia (difficulty swallowing); difficulty walking; contracture of left hand, and fracture of unspecified part of neck of left femur. Review of Resident R37's clinical record revealed Resident R37's Comprehensive Minimum Data Set Assessment (MDS- periodic assessment of a resident's needs) dated December 2, 2025, indicated the resident was cognitively impaired. Continued review of the MDS assessment revealed the resident was dependent on staff for toilet hygiene, sit to stand transfer, lower body dressing and toilet transfers. Review of Resident R37's Care Needs as noted by the companion agency who employed Resident R37's companion dated November 11, 2025, to current revealed, facility staff are to do all personal care for the resident. Additional review of same document revealed for Resident R37's personal care and toileting, the resident's Care Needs indicated [NAME] staff is responsible for all transfers and personal care. Continue review of the companion agency documentation revealed the companion agency staff were to alert facility staff when personal care is needed by the resident. Review of Resident R37's Activities of Daily Living (ADL's) as noted by the companion agency dated November 11, 2025, to current; revealed companion staff should request transfers from facility staff for the resident on all shifts. Review of information submitted March 14, 2026, by the facility to the Department, revealed Resident R37's nurse aide found the resident sitting on the toilet in the bathroom located in (his/her) room, accompanied by (his/her) companion from the 7:00 a.m. to 3:00 p.m. nursing shift. Continued review of information revealed the resident's companion indicated the resident fell off the toilet and (the companion, Employee E8) picked the resident up and put him back on the toilet. Further review of the documentation revealed Resident R37 had severe cognitive impairment, non- ambulatory and needed the maximum assistance of two people for transfers. Continued review of the information revealed the companion reported the resident was standing outside of the bathroom when she saw the resident stand quickly and fall to the floor. Additional review of the information revealed the companion indicated she could not get to the resident in time to prevent the fall. Further review of the information revealed the resident complained of hip pain. An x-ray was obtained at the facility, and the results of the x-ray showed the resident sustained an acute left femoral intertrochanteric fracture (left hip fracture). Continued review revealed the resident was sent to the hospital emergency room for treatment. Review of Employee E4's (nurse aide) witness statement dated March 14, 2026, regarding the above-referenced incident revealed the nurse aide reported both she and the licensed nurse (Employee E10) put the resident on the toilet and informed the companion to ring the call bell when the resident was finished. Nurse aide reported that the companion told her the resident fell and then she informed the nurse. During interview with the nurse aide, Employee E4 on April 30, 2026, at 1:08 p.m. the nurse aide revealed both she and the licensed nurse supervisor (Employee E10) put the resident on the toilet and the resident fell off the toilet when the resident was left with the companion. Nurse aide, Employee E4 revealed the companion was standing in the bathroom doorway after Licensed nurse, Employee (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E10 put the resident on the toilet. Nurse aide, Employee E4 revealed the companion told her that she took the resident off the floor and put the resident back on the toilet. Nurse aide, Employee E4 revealed she informed another nurse (Employee E9) what the companion had confided to her about the resident falling off the toilet and the companion picking the resident up from the floor and put the resident back onto the toilet. During interview with Licensed nurse (Employee E9) on April 30, 2026, at 1:34 p.m. revealed that nurse aide (Employee E4) notified her that the resident fell off the toilet and the resident's companion picked him off the floor and put him back on the toilet so the resident could finish using the bathroom. Licensed nurse, Employee E9 reported she notified the nurse supervisor (Employee E10). Licensed nurse, Employee E9 revealed when she walked into the resident's room after the nurse aide called, the resident was observed sitting in his wheelchair next to the table in his room facing the door. Review of the facility's investigation did include a written statement from licensed nurse (Employee E9). During follow up interview with nurse aide (Employee E4) on April 30, 2026, at 1:45 p.m. the nurse aide revealed the resident was on the toilet when she went back into the bathroom to answer the call bell, and that both she and the companion transferred the resident from the toilet to the resident's wheelchair. Review of written statement by nursing supervisor (Employee E10) dated March 14, 2026, revealed nursing supervisor indicated she assisted the nurse aide (Employee E4) with transferring the resident to the toilet. The nursing supervisor reported in her statement she instructed the resident's companion to ring the call bell when the resident was finished using the bathroom. Interview conducted with nursing supervisor (Employee 10) on April 10, 2026, at 1:47 p.m. nursing supervisor reported she helped the nurse aide transfer the resident to the bathroom toilet located in the resident's room. Nursing aide indicated the companion was sitting on the chair across from the resident outside of the bathroom in the resident's room when they left the room. Nursing supervisor reported she instructed the companion to pull the call bell in the resident's room when the resident was finished using the bathroom. Nursing supervisor revealed the licensed nurse (Employee E9) came to her and informed her that the resident fell off the toilet and the companion picked the resident up. Nurse supervisor indicated she went to the resident's room, and the resident was sitting in his wheelchair. Nurse supervisor reported, she spoke with the companion and was informed by the companion the resident stood up from the toilet and by the time she got to the resident, the resident fell to the bathroom floor. Nurse supervisor reported she was pretty sure the nurse aide (Employee E4) and the companion transferred the resident from the toilet to the chair. Nursing supervisor reported Resident R37 requires two staff members for transfers and companions are not permitted to assist staff with transferring a resident in the facility. Review of written statement by Resident R37's companion (Employee E8) revealed the companion reported the resident was on the toilet and she was waiting outside the bathroom when she saw the resident quickly stand. The companion reported in her statement she tried to go towards the resident but the resident fell before she could get to the resident. Continued review of the companion's statement revealed she picked the resident from the floor and sat the resident back on the toilet. Interview conducted with companion (Employee E8) on May 11, 2026, at 1:20 p.m. revealed she works as a paid companion from a nursing agency for shift times of 7:00 a.m. through 7:00 p.m. every other Saturday. Employee E8 reported that she is not permitted to provide personal care or transfer residents. Continued interview with the companion regarding the incident of March 14, 2025, revealed the resident was transferred to the toilet by two staff members of the facility and she stood outside the bathroom door with the door open, to provide the resident privacy. The companion revealed, the resident stood up quickly that she could not do anything about it. Resident R37's companion, Employee E8 reported that she ran to the resident as soon as she saw him stand. The companion revealed Resident R37 fell; then she picked the resident up from the bathroom floor and pulled the call bell in the bathroom for help. Companion reported that she did assist the nurse aide (Employee E4) with transferring the resident to his wheelchair once the nurse aide came in. During an interview with the Director of Rehabilitation on April 30, 2026. at 2:41 p.m. it was confirmed that the resident's transfer status at the time of his fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required the resident to have the assistance of two staff members. During an interview with the Director of Nursing (DON) on April 30, 2026, at 2:25 p.m., concerns for Resident R37's supervision and safety were discussed. Further it was discussed with the facility Director of Nursing that the resident was transferred off the floor after a fall incident in the bathroom and into a wheelchair by a companion. 28 Pa. Code 211.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services