

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Luther Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 2781 Luther Drive Chambersburg, PA 17202	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on facility policy review, clinical record review, review of facility documents, and resident and staff interviews, it was determined that the facility failed to report an allegation of abuse and/or neglect to the required agencies in a timely manner for two of two residents reviewed (Residents 6 and 17).</p> <p>Findings include:</p> <p>Review of facility policy, titled Abuse/Neglect Exploitation Prevention Standard for Skilled Care, with a last revised date of October 4, 2017, and a last review date of May 21, 2025, revealed, in part, physical abuse is defined as, but not limited to, hitting, slapping, pinching, kicking, or handling in a rough manner; neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; the willful deprivation by a caretaker of goods and services which are necessary to maintain physical or mental health; the Administrator/designee notifies the local Area Agency on Aging of the allegation immediately; in addition, any allegations of sexual abuse, physical abuse involving serious physical injury, serious bodily injury, or suspicious death are reported immediately to state survey agency no later than two hours after forming the suspicion. If no serious bodily injury is involved, the timeframe for reporting a reasonable suspicion is within 24 hours.</p> <p>Review of Resident 6's clinical record revealed diagnoses that included muscle weakness, Charcot's joint of right ankle/foot (condition characterized by joint damage due to loss of sensation), and chronic non-pressure ulcer of the right heel.</p> <p>During a resident interview with Resident 6 on May 27, 2025, at 10:21 AM, Resident 6 indicated that she had experienced a fall from the mechanical sit to stand lift. She further indicated that she believed the nurse aide did not have her in the lift correctly.</p> <p>Review of Resident 6's care plan revealed a care plan focus for at risk for falls due to limited mobility, right Charcot joint to foot/ankle with a last revision date of January 19, 2022; and activities of daily living impaired due to weakness, medical comorbidities, and limited to extensive assistance with most tasks, with a last revision date of December 29, 2022. Interventions included, but were not limited to, transfer assistance of two with a mechanical sit to stand lift with an initiated date of February 1, 2023.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 6's clinical record revealed a nursing note dated May 4, 2025, at 9:45 AM, that indicated Resident had a witnessed fall earlier this AM, with a CNA [nurse aide] in room. CNA was changing resident brief, while using stand lift, and resident slid out of stand lifts secure device and fell to the floor.</p> <p>Review of facility provided incident report dated May 4, 2025, for Resident 6's fall indicated that Resident 6 fell during a brief change with a nurse aide while using stand-up lift and had no noted injury. Resident 6's description of the event indicated the same. The incident investigation determined that the nurse aide providing care neglected to follow Resident 6's care plan for assistance of two staff and neglected to follow facility policy, which required the use of two team members with a mechanical lift.</p> <p>The facility documentation failed to reveal any reports to any of the required agencies to include the local Area Agency on Aging and state survey agency.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) on May 29, 2025, at 12:04 PM, she confirmed Resident 6's fall was the result of the nurse aide neglecting to follow Resident 6's care plan and the facility policy. She confirmed that the facility did not report Resident 6's fall as a result of neglect to any of the required agencies, and indicated that it should have been reported to all the required agencies.</p> <p>Review of facility provided grievance log for May 2025 revealed that Resident 17 filed a grievance on May 14, 2025, which indicated that a staff member had kicked him.</p> <p>Review of the facility provided grievance form and investigation revealed that the Director of Nursing was notified on May 13, 2025, at 7:33 PM, that Resident 17 alleged that the nurse aide providing his care that evening had kicked his foot a few months ago when he had a fall to get him to stand up.</p> <p>The documentation provided for review revealed that the facility completed an investigation and found that the abuse was unsubstantiated. Facility documentation failed to reveal any reports to any of the required agencies to include the local Area Agency on Aging and state survey agency.</p> <p>During a staff interview with the NHA on May 29, 2025, at 12:06 PM, she confirmed that based on the nature of Resident 17's allegation of physical abuse, it should have been reported to the required agencies.</p> <p>28 Pa. Code 201.14(a)(c) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p>		