

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  06/11/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on facility policy review, clinical record review, facility documentation review, and staff interviews, it was determined that the facility failed to provide adequate supervision and assistance devices to prevent accidents, resulting in actual harm as evidenced by a fall with facial injury, which required sutures for one of three residents reviewed for falls (Resident 1).</p> <p>Findings include:</p> <p>Review of facility policy, titled Risk Management Incident/Accident Reporting Standard, with a last review date of May 21, 2025, revealed the facility identifies potential safety hazards, identifies residents at risk for accidents and/or falls and adequately plans care and implements procedures to prevent accidents.</p> <p>Review of facility policy, titled Resident Fall Prevention/ Prevention of Injury Standard, with a last revised date of November 28, 2017, and a last review date of May 21, 2025, revealed Residents will receive appropriate preventative measures and intervention to reduce risk for falls or injury; and Each member of the community, including team members, volunteers, and family members will support the safety of the residents' environment.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included Parkinson's disease (a movement disorder that affects the nervous system and worsens over time), weakness, and dementia (loss of cognitive functioning that interferes with daily life and activities).</p> <p>Review of Resident 1's care plan revealed a focus area of, I am at risk for falls due to Parkinson's, history of falls, and generalized weakness, effective March 21, 2025.</p> <p>Review of interventions related to the focus area revealed the following intervention: I should be seated in a BRODA chair [specialty wheelchair] in tilt position with L[left] lateral support at all times except full upright for meals to facilitate increased comfort and pressure reduction. The specialty chair is not considered a restraint for me as it does not change my transfer status and ability to get up from a seated position, effective March 21, 2025.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility incident report dated June 2, 2025, revealed that at 11:20 AM two therapy staff heard Resident 1 calling for help upon entering the nursing unit. Resident 1 was found in the common area on the floor in front of her broda chair, sitting on her bottom while bracing herself with her arms behind her back. Blood was noted on her hands, face, neck and clothing from a gash below her right eye. When asked, Resident 1 stated she was reaching for a block on the floor and fell out of her chair. No block was present on the floor. 911 was called and Resident 1 was transported to the hospital for evaluation and treatment.</p> <p>Review of Emergency Department provider notes dated June 2, 2025, revealed that an approximately 5 centimeter laceration was noted to Resident 1's right lower eyelid, which was repaired with 15 sutures.</p> <p>Further review of the facility incident report revealed that upon investigation, it was discovered that Resident 1's broda chair was not reclined, and was in the upright position when she fell.</p> <p>Review of witness statement from Employee 1 (Physical Therapy Assistant) dated June 2, 2025, revealed that prior to Resident 1's treatment session, a nurse aide showed Employee 1 where Resident 1 was located on the unit. Employee 1 stated she found Resident 1 in the TV area in her wheelchair, in the upright position. After completion of her treatment session, Employee 1 stated she returned Resident 1 to the television area of her unit with the wheelchair in the upright position, the same as it was prior to treatment.</p> <p>During an interview with Employee 2 (Registered Nurse) on June 11, 2025, at 11:45 AM, she revealed that when she assessed Resident 1 post-fall, she noted that Resident 1's wheelchair was not in a reclined position.</p> <p>During an interview with the Nursing Home Administrator (NHA) on June 11, 2025, at 9:00 AM, she confirmed that Resident 1 was care planned to have her broda chair reclined to make it more challenging to get up unassisted, which would allow staff more time to respond to prevent a fall, but that Resident 1 was still able to independently get out of her wheelchair, even when it was reclined.</p> <p>During an interview with Employee 3 (Registered Nurse) on June 11, 2025, at 12:00 PM, she confirmed that Resident 1's wheelchair was care planned to be reclined for safety as well as comfort, and that Resident 1 could have fallen more easily if the chair was in an upright versus reclined position.</p> <p>During a subsequent interview with the NHA on June 2, 2025, at approximately 11:40 AM, she revealed that Employee 1 was a prn (as needed), not full-time, staff member. She also revealed that since the incident, the facility has implemented a protocol where therapy staff hand-off a resident to the nursing staff when returning them to their nursing unit.</p> <p>During a later interview with the NHA on June 2, 2025, at 12:12 PM, she revealed the expectation that Employee 1 should have followed Resident 1's care plan regarding the positioning of her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Employee 1 failed to follow Resident 1's care plan by failing to place her wheelchair in a reclined position when Resident 1 was returned to her nursing unit, resulting in harm, as evidenced by a fall resulting in a facial laceration requiring sutures.</p> <p>201.14(a) Responsibility of licensee</p> <p>201.18(b)(1)(e)(1) Management</p> <p>211.10(d) Resident care policies</p> <p>211.12(d)(1)(5) Nursing services</p>		