STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396146	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spiritrust Lutheran the Village at Luther Ridge	2781 Luther Drive Chambersburg, PA 17202

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33305 Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to review and revise the resident plan of care for two of 14 residents reviewed (Residents 6 and 8). Findings include: Review of facility policy, titled Comprehensive Care Planning Standard, with a last revised date of November 17, 2017, and a last review date of May 21, 2025, revealed E. The Care Plan is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments; and L. Care plans are evaluated and revised as the resident's status changes and with any goals or treatment refusals. Review of Resident 6's clinical record revealed diagnoses that included long term use of anticoagulants (blood thinning medication used to prevent/reduce blood clot formation), chronic total occlusion of the artery to the lower extremities, and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of Resident 6's care plan revealed a care plan focus for potential for bleeding/bruising due to aspirin and Plavix (a medication used to prevent platelets from forming clots) use, dated April 30, 2021. Review of Resident 6's clinical record revealed that she was hospitalized from March 21-25, 2025, and that her Plavix and aspirin were discontinued upon her return to the facility. Review of Resident 6's clinical record also revealed that she had an Admission 5 Day MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) with the assessment reference date (last day of the assessment period) of March 27, 2025, completed with a subsequent care plan review. During an interview with the Nursing Home Administrator (NHA) on May 29, 2025, at 12:02 PM, she indicated that Resident 6's care plan should have been revised when it was reviewed upon Resident 6's return to the facility or after her comprehensive assessment and subsequent care plan review. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's clinical record revealed clinical diagnoses that included cerebral palsy (a congenital disorder of movement, muscle tone, or posture) and Spondylosis (age-related wear and tear of the spinal disks). Review of Resident 8's clinical record revealed the Resident had a fall with major injury on May 14, 2025. A fall risk evaluation was completed on May 23, 2025, that revealed a score of 13, indicating the Resident is high risk for falls. A review of Resident 8's care plan revealed no current focus on risk for falls, and further review revealed the fall care plan was marked as RESOLVED on May 23, 2025. During an interview with the NHA on May 29, 2025, at 12:14 PM, the NHA confirmed that a fall care plan should be present on the care plan. 42 CFR 483.21(b)(2) Comprehensive Care Plans 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33305 Based on policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the practitioner was notified of missed medication administration when medications were unavailable for four of 13 residents reviewed (Residents 12, 14, 15, and 19) and failed to provide treatment in accordance with professional standards of practice and physician orders for one of 13 residents reviewed (Resident 25). Findings include: Review of facility policy, Medication Administration, last revised June 2023, revealed, If a medication is not available, staff will notify the pharmacy provider immediately. Notify resident and/or resident representative and provider if a missed dose would occur. Review of Resident 12's clinical record revealed diagnoses that included type II diabetes mellitus (condition characterized by high blood sugar levels due to insulin resistance and relative lack of insulin production) and central pain syndrome (chronic condition characterized by ongoing pain due to issues with the nervous system, often resulting from damage to the brain or spinal cord). Review of Resident 12's May 2025 MAR (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Gabapentin (used to treat nerve pain) three times per day for central pain syndrome. Further review of the MAR revealed that nursing staff documented that Gabapentin was not administered on May 17, 2025 (three missed doses) and on May 18, 2025 (three missed doses). Review of Resident 12's clinical record failed to reveal evidence that the practitioner was notified of the missed medication administrations. During an interview with the Nursing Home Administrator (NHA) on May 29, 2025, at 1:37 PM, she confirmed that she was unable to locate evidence that the practitioner was notified Resident 12's missed doses of Gabapentin. Review of the clinical record for Resident 14 revealed clinical diagnoses that included hospice (end of life status) and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability). A review of Resident 14's current care plan revealed the Resident had a psychosocial well-being problem related to her diagnosis of anxiety. Review of Resident 14's physician orders reveal that the Resident was ordered Lorazepam (antianxiety medication) 0.5 milligrams twice a day for anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 14's progress notes and medication administration record on October 14, 2025, at 7:00 PM; October 15, 2025, at 7:30 AM and 7:00 PM; and on October 16, 2025, at 7:30 AM and 7:00 PM, revealed the medication was not available to be administered as ordered for anxiety. There was no documentation in the progress notes that the physician was notified of the missed doses of Lorazepam. During an interview with the NHA on May 28, 2025, at approximately 1:00 PM, the NHA confirmed there was no documentation to confirm that the physician was notified about the missed doses of Lorazepam. Review of Resident 15's clinical record revealed diagnoses that included congestive heart failure (condition that happens when the heart cannot pump blood well enough to meet the body's needs) and shortness of breath. Review of Resident 15's May 2025 MAR revealed an order for Torsemide (diuretic) in the afternoon for congestive heart failure. Further review of Resident 15's MAR revealed that Torsemide was not administered on May 24, 2025. Review of Resident 15's clinical record failed to reveal evidence that the practitioner was notified of the missed medication administration. During an interview with the NHA on May 29, 2025, at 1:37 PM, she confirmed that she was unable to locate evidence that the practitioner was notified Resident 15's missed dose of Torsemide. Review of Resident 19's clinical record revealed diagnoses that included congestive heart failure and hypothyroidism (condition where the thyroid gland doesn't produce enough thyroid hormone leading to a slow down in metabolism). During an interview with Resident 19 on May 27, 2025, at 10:54 AM, she expressed concern over an incident where she had gone without her levothyroxine (synthetic thyroid hormone) because it was not available to administer to her. Review of Resident 19's April 2025 MAR revealed an order for levothyroxine daily for hypothyroidism. Further review of Resident 19's MAR revealed that levothyroxine was not administered on April 10 and 11, 2025. Review of Resident 19's clinical record failed to reveal evidence that the practitioner was notified of the missed medication administration. During an interview with the NHA on May 29, 2025, at 1:37 PM, she confirmed that she was unable to locate evidence that the practitioner was notified Resident 19's missed doses of levothyroxine. Review of Resident 25's clinical record revealed diagnoses that included charcot's joint, ankle and foot (a degenerative joint disorder characterized by progressive bone and joint destruction due to nerve damage), and gout (a form of inflammatory arthritis characterized by sudden, severe pain and swelling in the joints). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations made on May 27, 2025 at 12:29 PM, and May 28, 2025, at 9:41 AM, revealed a brace on Resident 25's right lower extremity. Review of Resident 25's physician orders failed to reveal orders for right lower extremity splint application or care. Review of Resident 25's progress notes, medication administration record, and treatment administration record failed to reveal documentation of Resident 25's right lower extremity splint. Review of Review of Resident 25's care plan failed to reveal a focus area or intervention for a right lower extremity splint. During an interview on May 29, 2025, with the Nursing Home Administrator (NHA) it was revealed that physician orders were now in place for Resident 25's right lower extremity splint and a care plan had been developed. The NHA stated it was the expectation of the facility that orders and a care plan would be in place. 201.14(a) Responsibility of licensee 201.18(b)(1) Management 211.12(d)(1)(2)(3)(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. 46253 Based on facility policy review, clinical record review, facility documentation review, and resident and staff interviews, it was determined that the facility failed to provide adequate supervision and assistance to prevent accidents for one of two residents reviewed for falls (Resident 6). Findings include: Review of facility policy, titled Risk Management Incident/Accident Reporting Standard, with a last revised date of November 28, 2017, and 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. 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. Review of facility policy, titled Limited Lift Environment Standard, with a last revised date of August 7, 2015, and a last review date of May 21, 2025, revealed F. Resident Transfer-Responsibilities: When a mechanical lift is used, two (2) team members are required. 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. 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. 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 failed to follow Resident 6's care plan for assistance of two staff and failed to follow facility policy, which required the use of two team members with a mechanical lift. During a staff interview with the Nursing Home Administrator on May 29, 2025, at 12:04 PM, she indicated that she was unsure why the nurse aide was attempting to change Resident 6's brief while having her positioned in the sit to stand lift. She confirmed that the aide did not follow Resident 6's care plan or facility policy, which resulted in a fall. She indicated that she would expect staff to follow a resident's care plan and facility policies. 201.4(a) Responsibility of licensee 201.18(b)(1) Management 211.10(d) Resident care policies 211.12(d)(1)(2)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33305 Based on policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident for four of 17 residents reviewed (Residents 12, 14, 15, and 19). Findings Include: Review of facility policy, Medication Administration, last revised June 2023, revealed, Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. Review of Resident 12's clinical record revealed diagnoses that included type II diabetes mellitus (condition characterized by high blood sugar levels due to insulin resistance and relative lack of insulin production) and central pain syndrome (chronic condition characterized by ongoing pain due to issues with the nervous system, often resulting from damage to the brain or spinal cord). Review of Resident 12's May 2025 MAR (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Basaglar subcutaneous solution (insulin) at bedtime for diabetes mellitus as well as an order for Gabapentin (used to treat nerve pain) three times per day for central pain syndrome. Further review of the MAR revealed that nursing staff documented that Basaglar was not adminstered on May 3, 2025; and Gabapentin was not administered on May 17, 2025 (three missed doses) and on May 18, 2025 (three missed doses). Review of corresponding nursing progress notes revealed the following: May 3, 2025 - Resident is to receive 14 units of Basaglar Kwikpen . No insulin pen found, including in omnicell. Per MAR, insulin pen is on order. ; May 16, 2025 (regarding Gabapentin) - Called pharmacy and reordered medication due to administering the last one and none being left in the cart or anywhere on the unit 30 day supply (quantity of 90) should arrive this evening. May 17, 2025 (regarding Gabapentin) - Waiting for med to arrive from pharmacy. Med out of stock in the omnicell also. and still waiting to come from pharmacy, and May 18, 2025 (regarding Gabapentin) - waiting for pharmacy to bring, None in stock. and not received from pharmacy. out of stock in omincelle and Waiting for med from pharm. During an interview with the Nursing Home Administrator (NHA) on May 29, 2025, at 1:37 PM, she confirmed that Resident 12's medications were not administered as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record for Resident 14 revealed clinical diagnoses that included hospice (end of life status) and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability). Review of Resident 14's physician orders reveal that the Resident was ordered Lorazepam (antianxiety medication) 0.5 milligrams twice a day for anxiety. Review of Resident 14's progress notes and medication administration record on October 14, 2025, at 7:00 PM; October 15, 2025, at 7:30 AM and 7:00 PM; and on October 16, 2025, at 7:30 AM and 7:00 PM, revealed the medication was not available to be administered as ordered for anxiety. During an interview with the NHA on May 28, 2025, at approximately 1:00 PM, the NHA confirmed the medication was not available due to a change in pharmacies. The NHA added that the new pharmacy delivered the electronic medication unit (Omnicell) on the evening of October 14, 2025, but there was no access to the unit because staff had to be trained on the new unit. Review of Resident 15's clinical record revealed diagnoses that included congestive heart failure (condition that happens when the heart cannot pump blood well enough to meet the body's needs) and shortness of breath. Review of Resident 15's May 2025 MAR revealed an order for Torsemide (diuretic) in the afternoon for congestive heart failure. Further review of Resident 15's MAR revealed that Torsemide was not administered on May 24, 2025. Review of corresponding nursing progress notes revealed that Resident 15's Torsemide was not administered due to awaiting pharmacy. During an interview with the NHA on May 29, 2025, at 1:37 PM, she confirmed that Resident 15's medications were not administered as ordered. Review of Resident 19's clinical record revealed diagnoses that included congestive heart failure and hypothyroidism (condition where the thyroid gland doesn't produce enough thyroid hormone, leading to a slow down in metabolism). During an interview with Resident 19 on May 27, 2025, at 10:54 AM, she expressed concern over an incident where she had gone without her levothyroxine (synthetic thyroid hormone) because it was not available. Review of Resident 19's April 2025 MAR revealed an order for levothyroxine daily for hypothyroidism. Further review of Resident 19's MAR revealed that levothyroxine was not administered on April 10 and 11, 2025. Review of corresponding nursing progress notes revealed the following: April 10, 2025 - Medication not available. Awaiting arrival from pharmacy, and on April 11, 2025 - medication not available. continue to wait for medication from pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the NHA on May 29, 2025, at 1:37 PM, she confirmed that Resident 19's medications were not administered as ordered. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46253 Based on facility policy review, clinical record reviews, and staff interview, it was determined that the facility failed to ensure that the licensed pharmacist's report of a medication irregularity was reviewed and acted upon for two of five residents reviewed for unnecessary medications (Residents 6 and 27). Findings include: Review of facility policy, titled Drug Regimen Review, with a last revised date of February 2023, and a last review date of May 21, 2025, revealed Drug regimen review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication; and 3. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within a reasonable time frame, the Director of Nursing, designee and/or the consultant pharmacist may contact the Medical Director. Review of Resident 6's clinical record revealed diagnoses that included knee pain and muscle weakness. Review of Resident 6's drug regimen review for February 18, 2025, revealed a pharmacist recommendation to review Resident 6's medication order for Voltaren/diclofenac gel (a topical nonsteroidal anti-inflammatory drug [NSAID] used for the temporary relief of joint pain associated with osteoarthritis) for the following identified concern to assist in administering this gel the manufacturer provides a dosing card. The proper amount of Voltaren gel should be measured using the dosing card supplied. The recommended dosing is 2gm[grams] for each elbow, wrist, or hand, and 4 gm for each knee ankle, or foot. Please clarify the order to include this dose. Orders with 'apply 1 application' or simply 'apply' are not specific enough. This recommendation was not reviewed or signed by Resident 6's physician. Review of Resident 6's drug regimen review for March 24, 2025, revealed that the pharmacist made the exact same recommendation as February 18, 2025, since Resident 6's physician had failed to respond. On this recommendation Resident 6's physician marked Disagree. No change indicated, Current Benefit Outweighs Potential Risk and signed and dated the form April 1, 2025. No order change was given. Review of Resident 6's current orders revealed an order for Diclofenac Sodium External Gel 3 % (Diclofenac Sodium) Apply to bilateral knees topically every 6 hours as needed for mild to mod pain, dated January 20, 2023, indicating that Resident 6 still had a medication order that failed to include a physician ordered dose to administer. Review of 27's clinical record revealed diagnoses that included muscle weakness and right shoulder pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 27's drug regimen review for February 18, 2025, revealed a pharmacist recommendation to review Resident 27's medication order for Voltaren/diclofenac gel for the following identified concern to assist in administering this gel the manufacturer provides a dosing card. The proper amount of Voltaren gel should be measured using the dosing card supplied. The recommended dosing is 2gm[grams] for each elbow, wrist, or hand, and 4 gm for each knee ankle, or foot. Please clarify the order to include this dose. Orders with 'apply 1 application' or simply 'apply' are not specific enough. This recommendation was not reviewed or signed by Resident 27's physician. Review of Resident 27's drug regimen review for March 24, 2025, revealed that the pharmacist made the exact same recommendation as February 18, 2025, since Resident 27's physician had failed to respond. On this recommendation Resident 27's physician marked Disagree. No change indicated, Current Benefit Outweighs Potential Risk and signed and dated the form April 1, 2025. No order change was given. Review of Resident 27's current orders revealed an order for Diclofenac Sodium External Gel 1 % (Diclofenac Sodium) Apply to right shoulder topically every 12 hours as needed for shoulder pain, dated February 16, 2025, indicating that Resident 27 still had a medication order that failed to include a physician ordered dose to administer. During a staff interview with the Nursing Home Administrator on May 29, 2025, at 12:02 PM, she confirmed that Resident 6's and 27's physician should have provided an order for the correct dose of Voltaren/diclofenac gel for nursing staff to administer. 28 Pa. Code 211.2(d)(3) Medical Director 28 Pa. Code 211.9(d) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49123 Based on surveyor observations, facility policy, and staff interviews, it was determined that the failed to place opened dates on medications in one of two medication rooms (Arlington Unit) observed. Findings Include: Review of facility policy, titled Multi-Dose Medication Storage, with a revision date of May 21, 2025, read, in part, Facility will date multi-dose vials when opened, for the purpose of infection control and to ensure product stability. Observation of the medication storage room refrigerator on May 29, 2025 at 11:00 AM, with Employee 1, revealed two open multi dose vials of Tuberculin solution (a sterile solution, primarily Purified Protein Derivative (PPD), used for diagnosing tuberculosis) with no open dates. During a staff interview with Employee 1 on May 29, 2025, at 11:00 AM, it was revealed that multidose vials should be dated when opened. During a staff interview on May 29, 2025 at 11:58 AM, with the Nursing Home Administrator (NHA), the NHA stated that it was the facility's expectation that multidose vials be dated when opened. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396146	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spiritrust Lutheran the Village at Luther Ridge	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)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46253 Based on review of the sign-in sheets for the facility's Quality Assurance Performance Improvement (QAPI) Committee and staff interview, it was determined that all the required members failed to attend at least one meeting in one out of three quarterly meetings. Findings include: Review of all available documentation submitted by the facility revealed that there was not one meeting within the fourth quarter of 2024 in which all required attendees attended. The Medical Director was not in attendance at the October 16, 2024, meeting; the Director of Nursing nor the Medical Director were present at the November 20, 2024, meeting; and the Infection Preventionist nor one additional facility staff member were present at the December 18, 2024, meeting. During an interview with the Nursing Home Administrator (NHA) on May 29, 2025, at approximately 12:06 PM, the NHA indicated that the facility QA committee meets monthly. She confirmed that there was no one meeting in the fourth quarter of 2024 that had all required attendees present. She further indicated that she would expect all required members to be in attendance at least one of the monthly QAPI meetings in a quarter. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46253 Based on review of personnel training records and staff interview, it was determined that the facility failed to ensure each nurse aide was provided with the required in-service training consisting of no less than 12 hours per year for two of five nurse aide employee records reviewed (Employees 2 and 3). Findings include: Review of facility provided training records for Employee 2 revealed that she only completed 10 hours of the 12 required hours of annual training in the past 12 months. Review of facility training records for Employee 3 revealed that she only completed 6 hours of the 12 required hours of annual training in the past 12 months. During an interview with the Nursing Home Administrator on May 29, 2025, at 11:07 AM, she confirmed that she would expect nurse aides to meet required training hours. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a) Staff development