STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395802	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
THORNWALD HOME STATE LICENSE NUMBER: 082802	442 WALNUT BOTTOM ROAD CARLISLE, PA 17013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abbreviated complaint survey completed on January 30, 2025, it was determined that Thornwald Home was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0607 SS=D		F 0607		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
THORNWALD HOME STATE LICENSE NUMBER: **082802**	**442 WALNUT BOTTOM ROAD** **CARLISLE, PA 17013**

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F 0607 SS=D	Continued from page 1 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. No individual resident has been identified. E2 has received training and education on the facility's abuse policy which covers the seven components of abuse. 2. The Executive Director/designee will review training records to validate that contracted care providers including UPMC Post Acute Providers have evidence of Annual or New Hire Abuse training within the previous year. 3. UPMC Post Acute Providers will be re-educated by the Executive Director/designee on the facility's abuse policy. 4. Monthly audits will be conducted for 3 months by the Executive Director or designee on facility training records to validate contracted care providers and UPMC Post Acute providers have completed annual abuse training or new hire abuse training within the previous year. Results of audits will be reported to the facility Quality Assurance Performance Improvement (QAPI) committee for	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0607 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0607	review and/or further recommendation.	

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F 0607 SS=D	Continued from page 3 Based on personnel training file review, facility policy review, and staff interview, it was determined that the facility failed to implement written policies and procedures by not completing annual abuse training for one of three personnel training records reviewed (Employee 2). Findings include: Review of facility policy, titled "Freedom from Abuse, Neglect, and Exploitation of Residents and Misappropriate of Resident Property," dated February 9, 2023, revealed "Employees, including those who work in the facility as consultants and volunteers will be educated upon hire during New Employee Orientation, Online Training Programs, and/or Information packets. Education will be provided annually and as needed; Covered individuals will receive training and education regarding the following: Identifying what constitutes abuse, neglect, exploitation, and misappropriate of resident property; Prohibiting and preventing all forms of abuse, neglect, misappropriate of property	F 0607		

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F 0607 SS=D	Continued from page 4 and exploitation; Recognizing signs of abuse, neglect, exploitation, and misappropriate of resident property; Reporting abuse, neglect, exploitation and misappropriate of resident property, including injuries of unknown sources and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal." The policy further indicated that an "Initial/Annual Acknowledgement (UCCH #1411) is provided to those vendors and contractors who do business with United Church of Christ Homes." Review of training transcript provided by facility for Employee 2 (a contracted Physician Assistant) revealed that the Employee had not received annual abuse training in the calendar year of 2024. During a staff interview with the Nursing Home Administrator (NHA) and Employee 2 (Assistant Director of Nursing) on January 30, 2025, at 3:32 PM, the NHA confirmed that there was no documentation of annual abuse to provide for Employee 2 or an annual acknowledgement as	F 0607		

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F 0607 SS=D	Continued from page 5 indicated in the facility policy. She confirmed that she would expect all staff, including contracted staff, to receive this training on an annual basis. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.20(a)(5)(d) Staff development 28 Pa. Code 201.29(a) Resident rights	F 0607		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 6 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	1. R1's initial allegation documented on 1/9/25 was identified by the facility on 1/14/25, and reporting requirements to the Department of Health, Area of Aging, Local Police, and the PA Department of Aging occurred immediately. 2. The Executive Director spoke with E2 and the Medical Director about reporting immediately any allegations of abuse/neglect. An audit was conducted of Physician progress notes dated 12/9/24—1/30/24. No other documented allegations of abuse were identified. 3. UPMC Post Acute Providers and facility staff will be re-educated by the Executive Director on immediate abuse reporting requirements. Physician Progress notes will be reviewed during daily clinical meetings for three months to ensure that there are no entries of risk, including allegations of abuse that have been unreported to the facility. 4. Weekly random audits of	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0609 SS=D	Continued from page 7	F 0609	physician progress notes conducted by the Executive Director or designee of at least 5 residents will occur x 3 months to validate any documented allegations have been immediately reported to the Executive Director. Results of audits will be reported to the facility Quality Assurance Performance Improvement (QAPI) committee for review and/or recommendation.	

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F 0609 SS=D	Continued from page 8 Based on facility policy review, clinical record reviews, facility documentation review, and staff interviews, it was determined that the facility failed to report an allegation of abuse in a timely manner for one of four residents reviewed (Resident 1). Findings include: Review of facility policy, titled "Freedom from Abuse, Neglect, and Exploitation of Residents and Misappropriate of Resident Property," dated February 9, 2023, revealed, in part, "Any incident of abuse must be reported to the Executive Director/Designee; All reports of alleged abuse/neglect shall be immediately and thoroughly investigated. The immediate response shall consist of: Social Services/Designee to interview the resident and if possible, obtain a signed statement from the resident. Interview with the person(s) reporting the alleged abuse/neglect and obtain a signed statement, if possible. Interview and obtain signed statements, if possible, from any witness or individual who has knowledge of the alleged	F 0609		

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F 0609 SS=D	Continued from page 9 incident. If any allegation of physical abuse is made, the nurse shall examine the resident. Findings of the examination must be recorded in the resident's medical record. Investigation of alleged sexual abuse requires a physical exam by a physician, unless the resident or resident representative expressly refuses." Review of Resident 1's clinical record revealed diagnoses that included chronic kidney disease (longstanding disease of the kidneys leading to renal failure), chronic combined systolic diastolic heart failure (heart failure in which the heart cannot pump [systolic] or fill [diastolic] properly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 1's clinical record revealed a physician progress note written by Employee 2 dated January 9, 2025, at 10:28 AM, that indicated they had visited with Resident 1 this date and that "she reported being assaulted in her genitalia.	F 0609		

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F 0609 SS=D	Continued from page 10 Specifically, she reported someone was cutting her in that area. She genuinely believes that these events occurred." The note further indicated, "I did later talk to her nurse, who reviewed prior nursing notes with me." The note indicated that Resident 1 was alert and oriented to person and time, and that Employee 2 believed Resident 1's thought content was delusional. The documentation of their physical assessment failed to include any documentation that an assessment of Resident 1's genitalia was completed because of their reported assault. Review of Resident 1's clinical record revealed a physician progress note written by Employee 2 dated January 14, 2025, at 9:52 AM, that indicated they had visited with Resident 1 this date to follow-up on their delusions. The note indicated that Employee 2 had spoken to Resident 1's nurse who described her mental state as improving and that, as Employee 2 continued the conversation with Resident 1, "she started to tell me again about being struck over the head, being assaulted in her genitalia, and being conspired against by staff." The note also	F 0609		

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F 0609 SS=D	Continued from page 11 indicated that Resident 1 was oriented to herself, and her thought content was delusional. The documentation of their physical assessment failed to include any documentation that an assessment of Resident 1 was completed because of their reported assault. Review of a facility provided witness statement written by Employee 6 (a Licensed Practical Nurse) dated January 30, 2025, revealed that on January 9, 2025, at approximately 8:20 AM, Employee 2 had approached them and was questioning them about Resident 1's delusions and accusations. The statement further indicated that Employee 6 "did not recall any specific comments regarding any 'assault towards genitalia'." Employee 6 said that they discussed side effects of medications, signs and symptoms of acute gastrointestinal illness, and possible side effects of dehydration that could be causing Resident 1 to experience delusions and confusion. During an interview with Employee 1 (Assistant	F 0609		

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F 0609 SS=D	Continued from page 12 Director of Nursing) on January 30, 2025, at approximately 10:55 AM, Employee 1 indicated that on January 22, 2025, at 10:30 AM, while reviewing the Physician Assistant's (PA-Employee 2) progress notes that morning in clinical meeting it was discovered that Employee 2 had documented that Resident 1 had been "assaulted in her genitalia" in a January 9, 2025, and January 14, 2025, progress notes. Employee 1 indicated that an investigation was initiated immediately when this was discovered. During a staff interview with the Nursing Home Administrator (NHA) and Employee 1 on January 30, 2025, at 3:32 PM, the NHA confirmed that she nor any other administrative staff were made aware of Resident 1's initial report of an allegation of sexual assault on January 9, 2025. She also confirmed that she nor any other administrative staff were made aware of Resident 1's continued allegation of sexual assault on January 14, 2025. The NHA confirmed that she would expect all staff to report all allegations of abuse immediately to her.	F 0609		

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F 0609 SS=D	Continued from page 13 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.20(a)(5) Staff development 28 Pa. Code 201.29(a) Resident rights	F 0609		
F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 14 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. A thorough investigation has been completed for R1's allegations to include written witness statements of nursing staff. R1 was interviewed by the Executive Director on 2/3/25 and confirms feeling safe in the facility. 2. The Executive Director/designee will review 24-hour report and physician/other practitioner progress notes over last 7 days to ensure that there are no unreported allegations of abuse. In addition, an audit will be conducted on any allegations occurring over the last 7 days to ensure thorough investigations are in place. 3. Licensed staff will be re-educated by the Executive Director on the facility's abuse policy which includes recognizing documentation that constitutes initiation of the facility's abuse policy, and on the steps for an immediate, thorough investigation to include interviewing and obtaining signed statements from any witness or individual who has knowledge of the alleged incident.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0610 SS=D	Continued from page 15	F 0610	4. Weekly audits of abuse investigations will be conducted by the Executive Director or Designee x 3 months to validate thorough investigations have been completed to include immediate measures implemented to protect resident safety, identification of perpetrator, if able and written statements are in place. Results of audits will be reported to the facility Quality Assurance Performance Improvement (QAPI) committee for review and/or recommendation.	

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F 0610 SS=D	Continued from page 16 Based on facility policy review, clinical record reviews, review of facility reported incidents, review of facility documentation, and staff interviews, it was determined that the facility failed to complete thorough investigations of abuse allegations and, therefore, failed to protect the safety of a resident during abuse investigations for one of four residents reviewed (Resident 1). Findings include: Review of facility policy, titled "Freedom from Abuse, Neglect, and Exploitation of Residents and Misappropriate of Resident Property," dated February 9, 2023, revealed, in part, "All reports of alleged abuse/neglect shall be immediately and thoroughly investigated. The immediate response shall consist of: Social Services/Designee to interview the resident and if possible, obtain a signed statement from the resident. Interview with the person(s) reporting the alleged abuse/neglect and obtain a signed statement, if possible. Interview and obtain signed statements, if possible, from any	F 0610		

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	395802	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0610 SS=D	Continued from page 17 witness or individual who has knowledge of the alleged incident. Upon notification that an employee is alleged to have committed abuse, the facility will: Ensure that the resident is safe. The individual may be suspended pending investigation. If the individual is not employed by the facility, the individual will be denied unsupervised access to the resident and visits may only be made in designated areas approved by the Executive Director/Designee." Review of Resident 1's clinical record revealed diagnoses that included chronic kidney disease (longstanding disease of the kidneys leading to renal failure), chronic combined systolic diastolic heart failure (heart failure in which the heart cannot pump [systolic] or fill [diastolic] properly), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 1 clinical record revealed a progress note written by Employee 4 (Director of Social Services) dated January 8, 2025, at 2:38	F 0610		

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F 0610 SS=D	Continued from page 18 PM, that indicated Resident 1's behavior care plan was updated related to "delusions that may include staff that are people of color." Further review of Resident 1's clinical record progress notes revealed a progress note written by Employee 3 (a Registered Nurse) dated January 8, 2025, at 2:39 PM, that indicated Resident 1 had told the Social Worker "I was out in the snow looked for the person who hit me in the head and pulled me. It was two black girls I'd know one if I saw her." The note also indicated that Resident 1 said to Employee 3 "I was hit on the head and dragged into the Cat Scan. They scanned my (pointed to private area). I was so full of urine. I had to relieve myself. I peed in the trash can. Now I am being punished." Review of facility provided investigation documentation revealed a statement written by Employee 4 (Director of Social Services) dated January 8, 2025, at 10:45 AM, indicated that she had stopped by to see Resident 1 and that she was	F 0610		

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F 0610 SS=D	Continued from page 19 tearful and said "They've maligned me in every way because I peed in the trash can. What would you do? I was out in the snow looking for the person who hit me in the head and pulled me." No other investigation or witness statements were provided as part of the investigation. Review of a facility reported incident with an original submission date of January 8, 2025, at 2:26 PM, indicated that Resident 1 had stated to Employee 4 that staff have "maligned me in every way because I peed in the trashcan. What would you do? I was out in the snow looking for the person who hit me in the head and pulled me." The report further indicated that the facility was unable to identify any individual involved. Further review of this report revealed that an update was submitted on January 13, 2025, indicating that the allegation was found to be unsubstantiated as the facility was "unable to identify a perpetrator." An update was submitted on January 16, 2025, that	F 0610		

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F 0610 SS=D	Continued from page 20 indicated, " At time of accusation, resident was experiencing increased confusion and delusions." The facility reported incident failed to indicate that Resident 1 had shared a description of the alleged perpetrator(s) and said that she would be able to identify her if she saw her or that the facility had taken any measures to identify the alleged perpetrator. During a staff interview with Employee 1 (Assistant Director of Nursing) on January 30, 2025, at 10:55 AM, Employee 1 confirmed that the facility does have female staff fitting the resident's description and that one had cared for Resident 1 on one shift. Employee 1 confirmed that she had not obtained investigation or witness statements from any nursing staff regarding Resident 1's allegation and that Resident 1 had not been asked to identify the alleged perpetrator. Although, Resident 1 had provided a description and said that she would be able to identify her if she saw her. Employee 1 indicated that she usually reviews clinical notes daily. Employee 1 indicated that Resident 1 had been	F 0610		

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F 0610 SS=D	Continued from page 21 discussed in the daily clinical meetings because of her changes in health status. She indicated that they utilize the 24-hour report from the facility's electronic health record to discuss residents. She further indicated that this was an electronic report and that do not print them. Review of a facility reported incident with an original submission date of January 22, 2025, at 12:22 PM, indicated that on January 22, 2025, at 10:30 AM, it was discovered that Employee 2 had documented that Resident 1 had been "assaulted in her genitalia" in a January 9, 2025, and January 14, 2025, progress note. Further review of this report revealed that an update was submitted on January 27, 2025, indicating that Employee 2 did not communicate the Resident's concern to any facility staff member; and on January 28, 2025, indicating that Employee 1 had provided Employee 2 with education on the abuse policy, and he was given a copy of the policy. Review of provided investigation documentation revealed a statement written by Employee 5 (a	F 0610		

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F 0610 SS=D	Continued from page 22 Social Worker) which indicated that they had interviewed Resident 1 on January 22, 2025, and Resident 1 stated that she was hit on the head and "a nurse was sticking something sharp inside of me". The resident also described the appearance of the two alleged employees. During a staff interview with the Nursing Home Administrator (NHA) on January 30, 2025, at 12:07 PM, the NHA indicated that, during daily clinical meeting, the interdisciplinary team reviews incidents and accidents, as well as verbal nursing reports. She said that the facility's electronic health record pulls a 24-hour report that reveals notes that have occurred in the prior 24 hours so that appropriate follow-up can be completed or initiated. When asked if open investigations are reviewed during this meeting, the NHA indicated that it depends on where they are in the investigation process and sometimes; they are not done in this meeting because of the nature of the investigation. The NHA attempted to pull 24-hour history reports from prior dates, but the system would not enable	F 0610		

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F 0610 SS=D	Continued from page 23 the report to be pulled. At time of conclusion of field office investigation on January 30, 2025, at 3:25 PM, the facility was unable to provide any documentation that indicated they had obtained investigation or witness statements from any nursing staff regarding Resident 1's abuse allegations or that Resident 1 had been asked to identify the alleged perpetrator(s). Although, Resident 1 had again provided a description and that she would be able to identify her if she saw her. During a staff interview with the NHA and Employee 1 on January 30, 2025, at 3:32 PM, the NHA confirmed that the facility had not thoroughly investigated Resident 1's allegations of abuse. She confirmed that Resident 1 was never asked to identify the alleged perpetrator(s); although, Resident 1 had provided a physical description and said that she would be able to identify her if she saw her again on two separate occasions over a 14-day timespan. The NHA confirmed that no staff	F 0610		

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F 0610 SS=D	Continued from page 24 members were suspended while the facility was completing the investigations for Resident 1. The NHA indicated that she would expect all abuse investigations to be completed thoroughly to enforce resident safety. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0610		

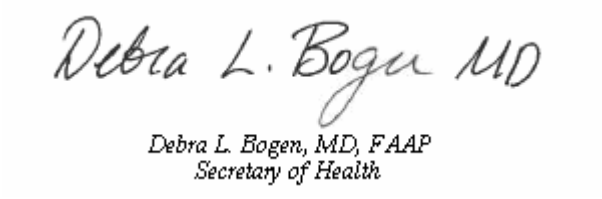
Certified End Page

THORNWALD HOME

STATE LICENSE NUMBER: 082802

SURVEY EXIT DATE: 01/30/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY