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:	12/11/2025

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 a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey which ended on December 11, 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 Facilities and the 28 PA Code, and Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0606 SS=D		F 0606		

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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F 0606 SS=D	Continued from page 1 483.12(a)(3)(4) Not Employ/Engage Staff w/ Adverse Actions §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by:	F 0606	1. No individual resident has been identified. Employee 3 and Employee 4 license verification were completed on 12/9/25. 2. An audit of current employee files of those with Licenses or Certifications was completed on 12/16/2025 to validate employee licenses or certifications are in good standing, and employees are fit for service. 3. Re-education to HR Payroll Benefit Coordinator, Receptionist and Nursing Leadership on the facility policy "Admin Freedom from Abuse Policy" will be provided by the Executive Director. The HR Payroll Benefit Coordinator or designee will verify licensure/certification and will print the verification prior to offering any position. This will be maintained in the HR office in the employee file. 4. The Executive Director, or designee will conduct weekly audits x 12 weeks of potential new hires to validate license/certification verification has occurred and is in employee file. Findings of audits will	Completion Date: **01/15/2026** Status: **APPROVED** Date: **12/24/2025**

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F 0606 SS=D	Continued from page 2	F 0606	be analyzed to identify/track trends or patterns and will be reported monthly to the facility Quality Assurance/Performance Improvement Committee for review and /or recommendation.	

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F 0606 SS=D	Continued from page 3 Based on facility policy review, personnel file review, and staff interviews, it was determined that the facility failed to ensure that residents were protected from the potential for abuse by failing to verify the standing of professional license prior to hire for two of five personnel files reviewed (Employees 3 and 4). Findings Include: Review of facility policy, titled "Admin Freedom from Abuse Policy," read, in part: "I. Screening A. To ensure resident safety, UCC Homes will not hire prospective employees with disciplinary action against their licenses or certification, which includes Individuals found guilty of abuse. Prospective employees will undergo screening within the allowable timeframes. The screening process shall include: Verification of active Licensure or Certification with the Department of State and the original display portion of licenses on file, if appliable. Verification of enrollment in Department of State registry, if applicable."	F 0606		

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F 0606 SS=D	Continued from page 4 Review of the personnel file for Employee 3 (Certified Nursing Assistant [CNA]), revealed Employee 3's nursing assistant certification was verified on December 9, 2025, indicating certification verification was not completed prior to Employee 3's date of hire on September 10, 2025. Review of the personnel file for Employee 4 (Licensed Practical Nurse [LPN]), revealed license verification with the Pennsylvania licensing board was completed on December 9, 2025, indicating license verification was not completed prior to Employee 4's date of hire on November 19, 2025. During an interview with the Nursing Home Administration on December 11, 2025 at 8:30 AM, it was revealed that Human Resources completes a check list to ensure all items are completed, to include verification of license, and the information is forwarded to the hiring manager. The hiring manager discards the information that is not entered into the	F 0606		

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F 0606 SS=D	Continued from page 5 employee's file. They were unable to locate verification of licensure verification completed prior to the hire dates for Employee 3 and Employee 4. 28 Pa Code 201.18(e)(1)(2) Management 28 Pa Code 201.19 Personnel policy and procedures	F 0606		
F 0641 SS=E		F 0641		

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F 0641 SS=E	Continued from page 6 483.20(g)(h)(i)(j) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	1. R 4 and R 14's Minimum Data Set (MDS) were modified on 12/9/25 to accurately reflect that a restraint was not in use. R 12's medical record was reviewed, and no PTSD diagnosis has been identified by the Provider. R 12 does have a trauma history which has been care planned, and the CMS 802 roster was updated to reflect the history of trauma on 12/9/25. The provider will be notified to evaluate if a post-traumatic stress disorder (PTSD) diagnosis is warranted. 2. An audit was completed on 12/9/25 for current residents coded as restraints on Section 0 of the MDS, and modifications were completed as necessary. An audit was completed on 12/9/25 to identify residents with a history of trauma and/or PTSD diagnosis. The 802 was manually updated to indicate the history of trauma for identified residents, but no PTSD diagnoses was identified in any resident. No modifications to MDS accuracy were identified. The physician/provider	Completion Date: **01/15/2026** Status: **APPROVED** Date: **12/24/2025**

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F 0641 SS=E	Continued from page 7 This REQUIREMENT is not met as evidenced by:	F 0641	will be notified to review identified residents to evaluate if a PTSD diagnosis is warranted. 3. The RNACs will be re-educated by the Executive Director on proper coding and accuracy of the MDS in its entirety with a focus on proper coding of restraints at Section O. In addition, education will be provided by the Executive Director to the RNACs that PTSD requires a physician diagnosis to be coded in Section I of the MDS and that the 802 rosters should be checked for PTSD diagnosis or identified history of trauma. The 802 roster will be submitted to DON weekly for review of accuracy of triggered items. The Interdisciplinary team completing sections of the MDS will be re-educated on accuracy of coding the MDS by the Executive Director 4. The Director of Nursing or designee will conduct weekly audits of at least 5 residents per week x 12 weeks to validate accurate coding of Section 0 for restraints and Section I for PTSD. Audits will include at least 1 MDS per week x 12 weeks reviewed	

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F 0641 SS=E	Continued from page 8	F 0641	in its entirety for accuracy. Findings of audits will be analyzed to identify/track trends or patterns and will be reported to the facility Quality Assurance/Performance Improvement Committee for review and/or recommendation.	

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F 0641 SS=E	Continued from page 9 Based on clinical record review, policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that resident assessments accurately reflected the resident's status for three of 18 residents reviewed (Residents 4, 12, and 14). Findings include: Review of policy titled Bed Entrapment Prevention Program, revised November 11, 2022, read, in part, monitoring of resident's health status that may affect the risk of bed entrapment will be done periodically (at least quarterly) to assess resident continued need for the device and document in the electronic medical record. Review of facility policy, titled Trauma Informed Care, revised October 2024, read, in part, trauma informed care shall be an integral part of a person-centered environment. This involves an interdisciplinary approach to care. Ensuring care and	F 0641		

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F 0641 SS=E	Continued from page 10 services are person-centered and reflect the resident's goal for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety. Review of Resident 4's clinical record revealed diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system) and weakness (decrease or loss of muscle strength). During an interview with Resident 4 on December 8, 2025, at 10:32 AM, an observation of a right sided enabler bar was made. Resident 4 reported he used the bar to help him move while in bed. Review of Resident 4's physician orders revealed an order for right side bed enablers. Review of Resident 4's quarterly minimum data sets (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) dated August 18, 2025, and October 28, 2025,	F 0641		

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F 0641 SS=E	Continued from page 11 revealed Resident 4 was coded for restraint use related to enabler bars. An interview with the Nursing Home Administrator (NHA) on December 9, 2025, at 11:15 AM, revealed that Resident 4's MDSs had been coded incorrectly, and a modification would be done to correct them. During an additional interview with the NHA on December 10, 2025, at 10:35 AM, the NHA stated that it was the expectation of the facility that MDSs accurately reflect the Resident's status. Review of Resident 12's clinical record revealed diagnoses that includedadjustment disorder with mixed anxiety and depressed mood. Interview with Resident 12 on December 8, 2025, at 11:50 AM, revealed that she had lost her son a year ago, and that was something she would never get over.	F 0641		

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F 0641 SS=E	Continued from page 12 Resident 12's care plan included a focus area for trauma informed care. The care plan indicated that Resident 12 witnessed someone choke and the heimlich was not successful. Resident chooses not to go to the dining room due to this experience, and services for counseling as indicated. Per Psychology consults dated September 22nd, 2025, and November 10th, 2025, it was documented that 50 percent of the session was related to grief/loss. Review of Resident 12's quarterly MDS dated November 7, 2025, section I (diagnoses) failed to document PTSD (post-traumatic stress disorder - a mental health condition triggered by experiencing or witnessing a traumatic event). Interview with NHA on December 9, 2025, at 11:15 AM, it was revealed that Resident 12's November 7th, 2025, MDS should've documented PTSD and that the CMS form 802 (Matrix) was updated to include the PTSD/trauma informed care	F 0641		

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F 0641 SS=E	Continued from page 13 designation. Review of Resident 14's clinical record documented diagnoses that included hemiplegia (paralysis or severe weakness affecting one side of the body). Observation in Resident 14's room on December 10, 2025, at 11:30 AM, revealed an enabler bar was on the right side of the bed. Resident 14's physician orders included a right-side enabler for bed mobility and increased independence, start date August 14, 2025. Resident 14's quarterly MDS dated September 12, 2025, revealed Resident 14's MDS was coded for restraint use related to enabler bars. Interview with NHA on December 9, 2025, at 11:30 AM, revealed that Resident 14's September 12th, 2025, MDS had been coded incorrectly, and a modification would be done to correct it.	F 0641		

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F 0641 SS=E	Continued from page 14 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0641		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 15 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. R 10's air mattress connector hoses were immediately replaced on 12/11/25 and set to the proper weight setting. A physician order was obtained to check the mattress for each shift for proper functioning and weight setting. 2. A facility wide audit was conducted on 12/11/25 to identify any resident with an air mattress. Physician orders will be obtained to check functioning and settings each shift. Most recent wound consultative reports will be reviewed by the Director of Nursing for any air mattress recommendations to validate follow-through. 3. Licensed nurses will be re-educated by the Director of Nursing on checking proper functioning/settings of air mattresses and follow-through of wound consult recommendations to promote healing of pressure ulcers. Licensed Nurses will sign each shift on the treatment record validating proper functioning and settings are in place for air mattresses. Wound consult reports will be reviewed	Completion Date: **01/15/2026** Status: **APPROVED** Date: **12/24/2025**

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F 0686 SS=D	Continued from page 16	F 0686	weekly during the daily interdisciplinary team meeting to validate that recommendations have supportive documentation for being addressed. 4. DON or designee will conduct weekly random direct observations of air mattresses across all 3 shifts for proper functioning, settings and documentation for a minimum of 12 observations per week x 12 weeks. DON or Designee will conduct weekly audits of 5 residents/week x 12 weeks receiving wound consultation for supportive documentation of follow-through of recommendations. Findings of audits will be analyzed to identify/track trends or patterns and will be reported to the facility Quality Assurance/Performance Improvement Committee for review and/or recommendation.	

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: _____	12/11/2025

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F 0686 SS=D	Continued from page 17 Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of one resident reviewed for pressure ulcers (Resident 10). Findings include: Review of facility policy, titled "Wound Management Program Infection Prevention and Control," dated February 2018, revealed, in part, "Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. The goal for a resident with a wound is one of promoting healing and preventing infection unless their preference and medical condition necessitate palliative care as the primary focus. Our facility's commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, evidence clinical guidelines, and	F 0686		

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F 0686 SS=D	Continued from page 18 interdisciplinary involvement." Review of facility policy, titled Skin Integrity Program: Pressure Ulcer Prevention/Treatment Program," dated April 27, 2023, revealed, in part, "Based on a comprehensive assessment, the facility shall ensure that a resident who enters the facility without a pressure ulcer does not develop pressure ulcers unless the clinical condition demonstrates that they were unavoidable or if a pressure ulcer is present (e.g. time of admission) receives necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Revision of the interdisciplinary plan of care shall be based on the effectiveness of the interventions." Review of Resident 10's clinical record revealed diagnoses that included pressure ulcers (area of damaged skin and tissue caused by sustained pressure which reduces blood flow to the area) on the right heel, right buttock, and left heel; type II diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high,	F 0686		

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F 0686 SS=D	Continued from page 19 but may not require the use of insulin); and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Observations of Resident 10 on December 8, 2025, at 11:45 AM, and December 9, 2025, at 12:25 PM, revealed that he was up in his wheelchair in his room. He was noted to have an air overlay mattress on his bed, but the pump was off. Observation of Resident 10's room on December 10, 2025, at 1:53 PM, revealed that his air overlay mattress pump was off. Observation of Resident 10 on December 11, 2025, at 8:38 AM, with Employee 1 (Registered Nurse) and Employee 2 (Assistant Director of Nursing) revealed the Resident was in bed. The air overlay mattress pump was turned off and the connecting air hose on the overlay mattress was not connected to the pump. The connecting hose was noted to be on the floor at the foot of the bed. In	F 0686		

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F 0686 SS=D	Continued from page 20 addition, the pump was set to the setting for a Resident weight of 300 pounds. Employee 1 attempted to connect the hose to the pump, but the hose would not remain latched because the securing clip was broken off. Employee 2 pressed the power switch, but the pump did not come on. Employee 2 then checked to see of the cord was plugged in to the power source. Employee 2 indicated it was plugged in. Surveyor pressed the power switch, and the pump came on and then shut off. Employee 2 again checked the cord, and the pump came on and stayed on. Employee 2 indicated that she would contact maintenance to evaluate the electrical outlet and the air overlay mattress. Review of Resident 10's clinical record revealed that he weighed 159.2 pounds on December 1, 2025. Review of Resident 10's physician orders revealed an order for wound consult services for skin/wound conditions/prevention as needed, dated August 12, 2025.	F 0686		

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F 0686 SS=D	Continued from page 21 Review of Resident 10's clinical record revealed that he had been seen weekly by the wound consultant weekly since October 1, 2025. Further review of Resident 10's clinical record revealed the following: 1) the pressure ulcer to his right heel developed at the facility on September 22, 2025, and was currently classified as a unstageable (pressure ulcer where depth cannot be determined due to presence of necrotic tissue called eschar); 2) the pressure ulcer to his right buttock developed at the facility on October 31, 2205, and was currently classified as an unstageable; and 3) the pressure ulcer to his left heel developed at the facility on November 4, 2025, and was currently classified as a Stage 3 (pressure ulcer characterized by full-thickness skin loss, exposing the fatty tissue beneath, and may present with slough-a moist yellowish colored dead tissue- or eschar, but does not expose bone or muscle). Review of Resident 10's wound consult note dated	F 0686		

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F 0686 SS=D	Continued from page 22 November 5, 2025, revealed that Resident 10 had developed two new pressure ulcers and indicated in the Assessment/Plan section of the note that he "would benefit from an air mattress for additional pressure relief." Review of Resident 10's wound consult note dated November 12, 2025, revealed that the unstageable right heel ulcer was worsening; the right buttock unstageable ulcer was stable; and the left heel Stage 3 was stable. The Assessment/Plan section of the note again indicated "would benefit from an air mattress for additional pressure relief." Review of Resident 10's wound consult note dated November 19, 2025, revealed that the unstageable right heel ulcer was improving without complications; the right buttock unstageable wound was stable; and the left heel stage 3 was worsening. The Assessment/Plan section of the note again indicated "would benefit from an air mattress for additional pressure relief."	F 0686		

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F 0686 SS=D	Continued from page 23 Review of Resident 10's wound consult note dated November 26, 2025, revealed that the unstageable right heel ulcer was improving without complications; the right buttock unstageable wound was now classified as a Stage 3 and was stable; and the left heel stage 3 was stable. The Assessment/Plan section of the note again indicated "would benefit from an air mattress for additional pressure relief." During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on December 10, 2025, at 3:05 PM, the NHA indicated that the air overlay mattress was placed on Resident 10's bed on November 21, 2025. Further review of Resident 10's clinical record failed to reveal a physician's order for an air overlay mattress or any documentation to support that the air overlay mattress was in place and the function/settings were being monitored between	F 0686		

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F 0686 SS=D	Continued from page 24 November 21, 2025, and December 10, 2025. During a staff interview with the NHA and Employee 2 on December 11, 2025, at 11:10 AM, Employee 2 indicated that maintenance had located the broken piece to the air hose under Resident 10's bed. She further indicated that maintenance replaced the air overlay mattress. The NHA confirmed that the pump should have been set for Resident 10's weight and that there were no orders prior today in place for staff to monitor the functioning or setting of Resident 10's air overlay mattress. The NHA confirmed that these measures should have been implemented when the air overlay mattress was initially placed on Resident 10's bed. She also added that they implemented education with staff about adding the monitoring of the air mattresses when they are ordered. During a staff interview with the NHA, DON, and Employee 2 on December 11, 2025, at 1:12 PM, the DON indicated that she had no documentation to provide to show why there was a three-week	F 0686		

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F 0686 SS=D	Continued from page 25 delay in applying the recommended air mattress on Resident 10's bed. She further indicated that she recalls that the interdisciplinary team had discussed Resident 10 in meetings in regard to the concern for the use of the air mattress and his high fall risk but could not provide supporting documentation of such. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0686		
F 0909 SS=D		F 0909		

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F 0909 SS=D	Continued from page 26 483.90(d)(3) Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by:	F 0909	1. R 14's bed was inspected by maintenance, and no area of entrapment was identified. 2. An audit was conducted throughout the skilled unit on 12/11/25 to identify current residents that have beds with rails. A Maintenance Bed evaluation and inspection was completed on the identified beds on 12/11/25 with no concerns noted. 3. Environmental Services will be re-educated by the Executive Director on the facility preventative maintenance program to include regular inspection of bed rails/enabler bars, and completion of the Bed Evaluation Tool. Education will include any device being added to the bed or frame requires inspection and completion of the Bed Evaluation Tool immediately upon adding to the bed or frame by maintenance. 4. Weekly audits x 12 weeks of residents with bedrails will be completed by Director of Nursing or designee to validate current bed rail inspection is documented at least	Completion Date: **01/15/2026** Status: **APPROVED** Date: **12/24/2025**

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F 0909 SS=D	Continued from page 27	F 0909	annually at the time of placing rails or enablers on bed if newly added, and when a significant change of condition occurs. Findings of audits will be analyzed to identify/track trends or patterns and will be reported to the facility Quality Assurance/Performance Improvement Committee for review and/or recommendation.	

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F 0909 SS=D	Continued from page 28 Based on observations, facility documentation, and staff interviews, it was determined that the facility failed to conduct regular inspection of all bed rails/enabler bars as part of a regular maintenance program to identify areas of possible entrapment for one of two residents reviewed with enabler bars (Resident 14). Findings include: Review of Resident 14's clinical record documented diagnoses that included hemiplegia (paralysis or severe weakness affecting one side of the body). Observation in Resident 14's room on December 10, 2025, at 11:30 AM, revealed an enabler bar was on the right side of the bed. Resident 14's physician orders included a right-side enabler for bed mobility and increased independence, start date August 14, 2025. Review of Resident 14's enabler bar assessment and	F 0909		

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F 0909 SS=D	Continued from page 29 consent for use of the enabler bar were signed August 14, 2025. Review of maintenance record for Resident 14's enabler bar (safety measurements) was dated April 10, 2025. Interview with the Nursing Home Administrator (NHA) on December 10, 2025, at 1:13 PM, it was revealed that assessment for use of enabler bars should be completed at minimum quarterly with the Minimum Data Set review (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) and the safety measurements are completed annually. Per Director Of Nursing on December 10, 2025, at 2:00 PM, it was revealed that Resident 14 had enablers placed on her bed in April 2025, and she requested they be removed due to not being able to see the "cats", so they were removed. Then the Resident asked for the enablers to be placed back on her bed in August 2025.	F 0909		

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F 0909 SS=D	Continued from page 30 During an interview with the NHA on December 11, 2025, at 10:20 AM, it was revealed the enabler bars weren't measured when they were placed back on the bed in August 2025, and measurements should've been completed at that time. 28 Pa. Code 201.18 Management 28 Pa. Code 205.71 Bed and furnishing	F 0909		

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P 0570	Restraint Restraint-A restraint can be physical or chemical. (i) A physical restraint includes any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the resident ' s body, cannot be removed easily by the resident, and restricts the resident ' s freedom of movement or normal access to the resident ' s body. (ii) A chemical restraint includes any medication that is used for discipline or convenience and not required to treat medical symptoms. This REGULATION is not met as evidenced by:	P 0570	1. R 27's dignity jumpsuit was evaluated on 12/9/25. A physician treatment order was obtained 12/9/25 to complete an evaluation every 30 days 2. A review of current residents reveals that no other residents have been identified as utilizing restraints. 3. Licensed Staff will be re-educated on restraints, proper documentation, and evaluations every 30 days for ongoing use of restraints. 4. Director of Nursing or designee will audit residents with restraints weekly x 12 weeks to validate evaluations of the restraint are completed every 30 days. Findings of audits will be analyzed to identify/track trends or patterns and will be reported to the facility Quality Assurance/Performance Improvement Committee for review and/or recommendation.	Completion Date: **01/15/2026** Status: **APPROVED** Date: **12/23/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0570	Continued from page 1 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to complete an evaluation every 30 days for the ongoing use of a restraint for one of one resident reviewed (Resident 27). Findings include: Review of facility policy, titled "Restraints," dated July 2025, revealed, in part, "7. The interdisciplinary team shall review and reevaluate the use of all restraints ordered by the physician or physician's delegee. On-going re-evaluation will occur every 30 days, or sooner as needed." Review of Resident 27's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and trisomy 21 (down syndrome- a genetic condition caused by the presence of an extra copy of chromosome 21, leading to developmental and physical differences).	P 0570		

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THORNWALD HOME STATE LICENSE NUMBER: 082802	442 WALNUT BOTTOM ROAD CARLISLE, PA 17013

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P 0570	Continued from page 2 Review of Resident 27's physician orders revealed orders for a dignity suit one piece outfit at night and need order renewal for dignity suit every 30 days, both dated July 15, 2025. Review of Resident 27's care plan revealed a care plan problem for Behavioral Symptoms, which indicated that Resident 27 "has behavioral symptoms as evidenced by smearing and eating feces" with an intervention for a dignity jumpsuit when in bed for the night, dated July 15, 2025, and dignity jumpsuit to be removed for 10 minutes every two hours, dated July 21, 2025. Review of Resident 27's progress notes revealed a physician progress note dated July 17, 2025, at 7:30 PM, that indicated the physician saw Resident 27 on July 15, 2025, as asked by nursing "due to concerns related to patient behavior. He has been progressively reaching for feces in his briefs. He sometimes spreads the feces on the remainder of his body and has also been noted to place it into his	P 0570		

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:	12/11/2025

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

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P 0570	Continued from page 3 mouth. I was asked to see him today for face-to-face evaluation and consideration of dignity suit." The note further indicated that the physician was in agreement with the use of the one-piece dignity jumpsuit. Review of Resident 27's clinical record revealed that he had an initial Equipment Assessment and Consent completed on July 14, 2025, for the utilization of the one-piece dignity jumpsuit. Further review of Resident 27's clinical record revealed that he had follow-up Equipment Assessments completed on October 2, 2025, and December 9, 2025, for the ongoing use of the one-piece dignity suit. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on December 10, 2025, at 10:43 AM, the NHA indicated that they had initially entered an ancillary order for the monthly evaluations, but ancillary orders do not populate anywhere to be completed.	P 0570		

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: _____	12/11/2025

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P 0570	Continued from page 4 She confirmed that Resident 27's restraint evaluation should have been completed at a minimum of every 30 days.	P 0570		

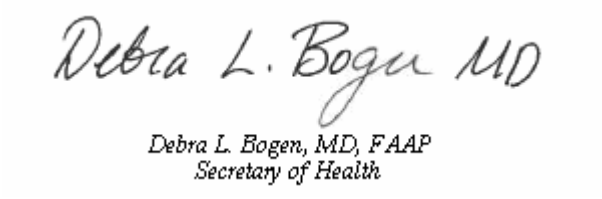
Certified End Page

THORNWALD HOME

STATE LICENSE NUMBER: 082802

SURVEY EXIT DATE: 12/11/2025

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