STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Rehab and Health	246 Friendship Circle Beaver, PA 15009

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to protect a resident from physical abuse that resulted in the actual harm of left comminuted displaced intertrochanteric fracture (a break in the upper thigh bone) that required surgery for one of three residents (Resident R1).Findings include: Review of the facility policy Abuse: Protection From last reviewed 10/1/25, indicated each resident has the right to be free from abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/31/26, indicated the diagnosis of traumatic brain injury (TBI), anxiety, and mild neurocognitive disorder due to know physiological condition with behavioral disturbance. Section C0500 Brief interview for mental status (BIMS- a screening test that aids in detecting cognitive impairment) score 13 indicated cognitively intact. Review of nursing progress note dated 4/23/26, at 10:51 p.m. indicated supervisors urgently called to unit 2 Main at 8:30 p.m. for a resident attacking staff. Upon exiting the elevator, resident was noted to be lying on his right side, screaming, complaining of pain to his left hip. When asked what happened, resident stated that big mother------ tackled me I was going to knock his ass out. Resident R1 reportedly with increasing agitation throughout the evening, and resident attempted to punch the nurse and nurse aides. Nurse reported that when the resident swung at him, the nurse grabbed the resident's arm/shoulder and took him down to the floor. Resident with 10/10 left hip pain, with left leg shortening and external rotation. Emotional support provided. Physician notified and received order to send resident to local emergency room. Review of facility provided statement dated 4/23/26, completed by Registered Nurse (RN) Employee E1 indicated this nurse heard Resident R1 yelling in his room in an aggressive manner. This nurse and all staff went to Resident R1's room to see what was going on. Resident was yelling at Nurse Aid (NA) because she wanted to move the roommate's wheelchair further away so roommate cannot attempt to self-transfer. Resident was agitated and was saying that he personally had moved the wheelchair to stay next to the roommate because it was obstructing his window view. Resident was cursing at the NA. Staff attempted to calm resident down but were unsuccessful, Resident continued to pace in his room while yelling and cursing. Resident walked out of room and went down the hall to the bathroom. After about 5 minutes the resident came down to the nursing station yelling. Resident had both fists folded and moved forward and was actively swinging. This nurse grabbed his arm and moved away to avoid being punched. Resident lost his balance and this nurse assisted him to the floor and was able to restrain him until the supervisors came up. Review of witness statement completed on 4/23/26, by RN Employee E17 indicated called urgently to 2 Main around 8:30 p.m., for Resident R1 attacking staff (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Friendship Rehab and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 246 Friendship Circle Beaver, PA 15009	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	members, Resident was lying on his right side on the floor in front of the elevator, screaming and holding on to his left hip. RN Employee E1 was standing over the resident holding the residents left arm to the resident's body to prevent him from striking staff. When asked what had happened, RN Employee E1 stated that Resident R1 was attacking staff and he grabbed his arm/shoulder and took him down to the floor. Resident R1 was yelling that big mother ------ tackled me. I was gonna knock his ass out resident complained of 10/10 left hip pain and left leg externally rotated. Physician called orders to send resident to the local hospital. Review of witness statement completed on 4/23/26, by Nurse Aid (NA) Employee E18 indicated I was charting about 8:00 p.m. and heard a loud commotion on the North Hall. Resident R1 was chasing and yelling at the NA about a wheelchair being moved to the wrong place. He was uncontrollable, The RN tried to talk to him. Resident R1 kept getting in the nurses' face telling him to go get his boys and saying he would teach him how to fight. The nurse left the room, and the resident went to the bathroom. After about 10 minutes Resident R1 came to the nursing station and started swinging, the nurse moved to the other cart and said he wasn't going to fight with him. Resident R1 swung and the nurse caught his swing by the forearm and was put to the floor by the nurse. Review of witness statement dated 4/23/26, completed by NA Employee E19 indicated I walked into Resident R1's room and saw resident residing in bed 1 sitting at the edge of bed with the wheelchair close by him. I walked over to Resident R1 and asked Resident R1 not to put the chair on that side because the resident residing in bed one can fall out of bed. Resident R1 goes to curse saying the chair was in his way and for me and the other NA to get out. The nurse heard the chaos and came down and Resident R1 got in the nurses' face and was saying I'll push you down. The nurse asked him to calm down. Resident walked into the bathroom. The nurse went down the hall. Resident came up to the nurse cart telling the nurse he was going to knock him out and asked if the nurse had a problem with him and started swinging at the nurse, The nurse grabbed him by the shoulder and sat him down on the floor. Review of the facility investigative report dated 4/24/26, at 8:44 a.m. indicated on 4/23/26, resident R1 was sent to emergency department for evaluation following an altercation with a staff member. Resident R1 was admitted to the hospital with a diagnosis of comminuted left hip fracture. Investigation started immediately. At approximately 8:30 p.m. nursing supervisor responded to unit due to report that Resident R1 was attacking staff. Upon arrival to the unit, Resident R1 was noted to be lying on the floor complaining of left hip pain. Resident R1 stated to nursing supervisor that big mother------ tackled me, referring to staff member Registered Nurse (RN) Employee E1. Resident R1 was immediately assessed for injury with left lower leg external rotation and shortening noted. Provider was contacted and gave order to send to emergency room for evaluation. Emotional support was offered. Family was called; police and APS were notified. Staff interviews were conducted. RN Employee E1 was interviewed and sent home pending investigation. RN Employee E1 reported that Resident R1 had been acting aggressively toward staff, and that Resident R1 came toward him and was threatening to knock him out. RN Employee E1 stated that Resident R1 swung at him and lost his balance, and he grabbed Resident R1 to assist him to the floor and restrained him until the supervisor came. Review of hospital history and physical dated 4/24/26, indicated [AGE] year-old male with past medical history of TBI, alcohol abuse with history of hepatic encephalopathy, apparently went into at Rehab center presented with left hip pain. Patient wanted to view the sunset and move a wheelchair which was obstructing his view. Apparently, staff told him not to do this and there was an altercation that pursued and when he was tackled to the ground the patient started having sever left hip pain and was brought to the emergency room. For further evaluation. Patient has some mild cognitive impairment baseline per record. Further review of Resident R1's hospital record confirmed a left comminuted displaced intertrochanteric fracture and Orthopedics was consulted for surgical correction. Resident has surgical intervention on 4/24/26. During an interview completed on 4/30/26, upon asking Resident R1 what happened to his leg stated, I was in my room, and a big wheelchair was blocking my view, so I moved it. The staff were bitching about me moving it. I went to the front desk to have them move the chair. I can't put it by the other (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	guy because he would try to get up. I told them I wanted to see the sunset. I have the right to look out the windows. He tackled me down to the floor. I broke my hip. It hurts it is swollen; they are giving me pain medication. This is my room. I can't remember, I couldn't move. I didn't need to be tackled. I don't have a weapon. He physically attacked me; he was over 200 pounds. I had to have surgery; I can't do anything. During an interview completed on 4/30/26, at 2:30 p.m. upon asking NA Employee E9 the process if a resident is exhibiting aggressive behavior stated, we are not allowed to restrain. I would just leave the room and call for help. During an interview completed on 4/30/26, at 2:36 p.m. upon asking RN Employee E10 the process if a resident is exhibiting aggressive behaviors stated, we are not allowed to restrain. I would ask for assistance, take the resident to a no-resident area, talk to the resident deescalate, see if someone else can help, find out what was triggering them and remove it If a resident fell, I would not restrain them to the ground. During an interview completed on 4/30/26, at 2:42 p.m. upon asking Licensed Practical Nurse (LPN) Employee E11 the process if a resident was exhibiting aggressive behaviors stated, back off, I'm not allowed to protect myself so I would back off and try to talk them down. I would expect to see interventions in the care plan. I would try to fix the trigger to calm down. During an interview completed 4/30/26, at 2:46 p.m. Upon asking RN Employee E12 the process if a resident is exhibiting aggressive behaviors stated, walk away, make sure they are safe, sometimes it's the approach, can call the physician. If I knew the cause I would remove it or the resident from it. If they wanted to fight, I would wait for them to calm down not allowed to restrain them for anything. During an interview completed on 4/30/26, at 2:50 pm upon asking LPN Employee E6 the process if a resident is exhibiting aggressive behaviors stated, I would look in the orders or care plans, call the supervisor to come down and help. Remove the trigger. During an interview completed on 4/30/26, at 2:56 p.m. upon asking LPN Employee E7 the process if a resident is exhibiting aggressive behaviors stated, I would try to redirect, give them time to cool off, let them walk around, remove other residents, call the physician the care plan should have interventions it depends on what is agitating them. Remove what is bothering, just give them time. During an interview completed on 4/30/26, at 3:00 p.m. upon asking LPN Employee E8 the process if a resident is exhibiting aggressive behaviors stated, I would see what was wrong, try to find the reason and remove what was agitating them. I would look in the care plan, progress notes, check the medication administration record (MAR). During an interview completed on 4/30/26, at 4:13 p.m. upon asking NA Employee E15 if she could recall an altercation that happened with Resident R1 replied that night we had a fall in the room, The roommate had a fall so we moved his wheelchair. I was in another room and heard him yelling, the NA was trying to explain to the resident that the chair can't be over by the resident explaining it really calmy, He was really mad about it, the nurse came in and tried to calm him down. The resident went to the bathroom, maybe it was like 5 minutes, and he ran out of the bathroom down to the nursing station. He attempted to hit the nurse. The nurse was trying to calm him down. There was a lot of commotion. I saw the nurse use a hand to try and stop him. He put him to the floor. When the resident was on the ground he was still punching. The nurse was holding his arms down. He calmed down when the supervisor came to the floor. During an interview completed on 4/30/26, at approximately 2:00 p.m. the Director of Nursing confirmed the investigation was not complete and stated I have been working on a plan of correction and have not completed the investigation. I am not going to substantiate, at what point do we protect our employees and confirmed that the facility failed to protect a resident from physical abuse that resulted in actual harm of left comminuted displaced intertrochanteric fracture that required surgery for one of three residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility investigations, and staff interview it was determined the facility failed to timely complete an investigative report for an allegation of physical abuse resulting in serious bodily injury for one resident of 3 residents (Resident R1).Findings include: Review of the facility policy Reporting Unusual Occurrences last reviewed 10/1/25, indicated unusual occurrences are reported by the facility to regulatory authorities as required by federal, state laws and local agencies. Appropriate agencies will be notified if the following events occur that include but not inclusive to:suspected, alleged or actual abuse, neglect, misappropriation of resident propertyfracturesincidents that necessitate a resident being transferred for medical evaluation regardless of admission to hospitalstaff to resident altercationA written report will be forward to all appropriate agencies within 5 working days or per regulation describing the event, circumstances, effects on residents, and actions taken by the facility.Review of the facility policy Abuse: Protection From last reviewed 10/1/25, indicated each resident has the right to be free from abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Review of the Code of Federal Regulations (CFR) S483.12(c)(4). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/31/26, indicated the diagnosis of traumatic brain injury (TBI), anxiety, and mild neurocognitive disorder due to know physiological condition with behavioral disturbance. Review of Resident R1's nursing progress note dated 4/23/26, indicated Supervisors urgently called to unit 2 Main at 8:30 p.m. for a resident attacking staff. Upon exiting the elevator, resident was noted to be lying on his right side, screaming, complaining of pain to his left hip. When asked what happened, resident stated that big mother------ tackled me. I was going to knock his ass out. Resident reportedly with increasing agitation throughout the evening, and per witness attempted to punch the nurse and nurse aids. Nurse reported that when the resident swung at him, the nurse grabbed the resident's arm/shoulder and took him down to the floor. Resident with 10/10 left hip pain, with L leg shortening and external rotation. Emotional support provided. Physician notified received order to send resident to local emergency room. Review of the Event Reporting System revealed a report was submitted to State Agency on 4/23/26, at 8:44 a.m. Review of facility provided investigation report on 4/30/26, at 10:00 a.m. did not include a PB-22, or outcome of investigation. During an interview completed on 4/30/26, at approximately 2:00 p.m. the Director of Nursing confirmed the investigation was not complete and stated I have been working on a plan of correction and have not completed the investigation. I am not going to substantiate, at what point do we protect our employees and confirmed that the facility failed to timely complete an investigative report for an allegation of physical abuse resulting in serious bodily injury for one resident of 3 residents (Resident R1). 28 Pa. Code 201.14(a)(c) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 211.10 (c) Resident care policies

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to develop a care plan that included instructions to provide person centered care for one of three residents (Resident R1).Findings include: Review of the facility policy Care Planning Implementation Guide: last reviewed 10/1/25, indicated Each resident will have an individualized interdisciplinary care plan developed that addresses the resident's needs as they are discovered through the assessment process. The overall care plan will be oriented towards but not inclusive to:Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence.Managing risk factors to the extent possible or indicating the limits of such interventionsAddressing ways to try to preserve and build upon resident strengths.Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.Involving the direct care staff with the care planning process relating to the resident's expected outcomes.Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.The care plan is initiated upon admission to the facility by the admitting nurse. From that point forward the care plan is updated as new information becomes available that needs to be addressed for the interdisciplinary team to provide care. Every significant event should be reviewed for the need to make a care plan or to update an existing care plan. Some examples include but not inclusive to:Negative resident interactionsResident fearsDangersAll Care plan items must be specific to the resident and consider their unique risks and strengths. All actual and potential issues should be addressed with the goal to promote the resident's highest practical level of functioning and well-being. This may be with the goal of improvement, maintaining, preventing avoidable decline, or managing symptoms. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/31/26, indicated the diagnosis of traumatic brain injury (TBI), anxiety, and mild neurocognitive disorder due to know physiological condition with behavioral disturbance. Review of Resident R1's current care plan indicated:Focus: Resident has a behavior problem of refusal of care and aggression; voiding in inappropriate areas related to TBI and alcohol abuse history, refusal to bathe/shower, refusal to change clothes, refusal for linen changes, disturbing other resident's televisions, remotes, and physical aggression.Goal: Resident will have fewer episodes of refusal of care and no aggression by review date.Interventions/Task: Anticipate and meet needs. Assist resident to develop more appropriate methods of coping and interacting by encouraging to express feelings appropriately, emotional support and psychology consult as needed. The care plan failed to include interventions for Residents R1's physical aggression, The care plan failed to include any interventions to apply when resident is experiencing physical aggression. During an interview completed on 4/30/26, at 12:26 p.m. upon asking Registered Nurse (RN) Employee E16, what the interventions are for a resident experiencing physical aggression stated, all of that should be in the care plan Upon looking at Residents R1's care plan RN Employee E16 stated that Resident R1's care plan failed to include interventions for physical aggression. During an interview completed on 4/30/26, at 12:54 p.m. Upon asking Licensed Practical Nurse (LPN) Employee E3 what she would do if a resident was experiencing physical aggression stated, I would look in the care plan for interventions. During an interview completed on 4/30/26, at 12:57 p.m. upon asking LPN Employee E4 what she would do if a resident was experiencing physical aggression stated, I would check the orders and care plan. We also have some residents that come in with a behavioral care plan that have interventions to use. During an interview completed on 4/30/26, at 1:00 p.m. upon asking RN Employee E5 what she would do if a resident was experiencing physical aggression stated, I would check the care plans they should have interventions, also look in the medication administration record (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sometimes they have it listed there. During an interview completed on 4/30/26, at approximately 2:00 p.m. the Director of Nursing confirmed that interventions were not included in Resident R1's current care plan and confirmed that the facility failed to develop a care plan that included instructions to provide person centered care for one of three residents (Resident R1). 28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.