STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395148	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Hill Rehabilitation and Healthcare Center	1555 East End Boulevard Plains Twp Wilkes Barre, PA 18711

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 a review of the facility's abuse policy, clinical records, facility-provided investigative documentation, and staff interviews, it was determined the facility failed to protect one of five residents reviewed (Resident 1) from non-consensual sexual contact by another resident (Resident 2) despite Resident 2's known history of documented inappropriate sexual behaviors. As a result, Resident 1 experienced actual harm when Resident 2 placed his hand underneath her clothing, touched her bare breast, and twisted her nipple, constituting non-consensual sexual contact.Findings included: A review of the facility policy titled Abuse Policy, last reviewed by the facility on January 21, 2026, revealed that its purpose is to establish policy and procedures to prevent, identify, investigate, and report abuse, neglect, exploitation of residents, and misappropriation of property, and to ensure residents are actively protected from such occurrences. The policy defined sexual abuse as non-consensual sexual conduct of any type with a resident. A review of Resident 2's clinical record revealed admission to the facility April 27, 2021, with diagnoses to include Type 2 diabetes (a chronic condition where the body either does not make enough insulin or it resists it) and restlessness and agitation. A review of Resident 2's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 5, 2026, revealed that Resident 2 was moderately cognitively impaired with a BIMS score of 8 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). A review of nursing documentation dated April 26, 2026, at 5:23 PM revealed Resident 2 exposed himself twice to another resident in the dining room. Documentation indicated Resident 2 was removed from the dining room and placed on one-to-one supervision (continuous observation by one staff member assigned to one resident). Review of facility investigative documentation dated April 26, 2026, at 4:00 PM revealed Employee 3, nurse aide, observed Resident 2 expose himself to another resident while Employee 3 was on break in the dining room. A witness statement completed by Employee 3 dated April 26, 2026, at 5:20 PM revealed Employee 3 observed Resident 2 sitting beside Resident 1 when he removed his penis from his brief. After Employee 3 redirected Resident 2, he replied, What, I'm itchy, and exposed himself a second time.A physician's order dated April 26, 2026, directed staff to provide one-to-one supervision for Resident 2. The order was discontinued on April 30, 2026. A review of Resident 2's care plan, initiated May 20, 2025, and revised March 17, 2026, identified behaviors including verbal aggression toward staff and residents and inappropriate interpersonal sexual behaviors. Planned interventions included administering medications as ordered, assisting the resident to develop appropriate coping and interaction skills, intervening as necessary to protect the rights and safety of others, removing the resident from situations when necessary, and monitoring behavioral episodes to identify contributing factors. A review of Resident 1's clinical record revealed admission to the facility on January 30, 2004, with diagnoses to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with (continued on next page)

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

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	395148	A. Building B. Wing	06/24/2026

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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 0600 Level of Harm - Actual harm Residents Affected - Few	personality change, resulting from organic disease of the brain), and schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). An admission Minimum Data Set assessment dated [DATE], revealed that Resident 1 was severely cognitively impaired with a BIMS score of 2 (a score of 0 through 7 indicates severe cognitive impairment). Due to her severe cognitive deficits, Resident 1 lacked the capacity to consent to any sexual contact or to independently defend herself from unwanted physical advances. Nursing documentation dated May 6, 2026, at 10:34 AM indicated that on May 5, 2026, at 1:45 PM Resident 2 was observed sitting beside Resident 1 in the dining room with his hand inside the front of her shirt. Staff immediately separated the residents, completed skin assessments, placed Resident 2 on one-to-one supervision, relocated him to another room, and referred him for psychological services. Review of the facility-provided investigative documentation dated May 5, 2026, at 1:45 PM confirmed Resident 2 was observed with his hand inside the front of Resident 1's shirt. Documentation indicated no injuries were identified, responsible parties were notified, Resident 2 was moved to another room, and one-to-one supervision was initiated. A witness statement completed by Employee 4, nurse aide, dated May 5, 2026, revealed Employee 4 observed Resident 2 with one hand underneath Resident 1's shirt on her bare breast while twisting her other nipple with his opposite hand. Employee 4 immediately separated the residents and notified the nurse and nurse supervisor. Review of the facility's report of abuse and neglect dated May 5, 2026, revealed the facility investigated the allegation and substantiated that sexual abuse occurred. Due to Resident 1's severe cognitive impairment documented on the June 9, 2026, MDS she was unable to reliably communicate the emotional or psychological effects of the incident or demonstrate whether she experienced fear, humiliation, or emotional distress following the event. Therefore, the reasonable person standard was applied. A reasonable person with similar vulnerabilities would likely experience unwanted sexual touching beneath their clothing, contact with a bare breast, and twisting of a nipple as invasive, humiliating, frightening, and emotionally distressing. This non-consensual sexual contact violated Resident 1's bodily integrity and dignity and resulted in actual psychosocial harm. During an interview on June 24, 2026, at 11:45 AM the Director of Nursing confirmed the facility's investigation substantiated the allegation of sexual abuse. The Director of Nursing acknowledged the facility failed to protect Resident 1 from non-consensual sexual contact by Resident 2 despite Resident 2's documented history of inappropriate sexual behaviors. 28 Pa. Code 201.29 (a)(c) Resident rights, 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies.