

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/03/2025 |
| NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046 | |

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 - Minimal harm or potential for 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. (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

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/03/2025 |
| NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046 | |
| 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) | | |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documentation, staff and resident interviews it was determined that the facility failed to protect residents from neglect for one of three residents (Resident R1). Findings include: Review of facility policy Abuse, Prevention of Resident Abuse, Neglect, Mental Abuse, Reports of Theft, Exploitation and Misappropriation of Property dated 8/18/25, indicated the facility will provide a safe and secure environment for all residents and will protect a resident's right to be free from any form of abuse, mental abuse, neglect, reports of theft, exploitation or misappropriation of resident property. Review of the facility policy Falls, Resident Treatment of dated 8/18/25, indicated all residents who fall will be evaluated immediately for injury. When a resident is found on the floor do not move resident until a licensed nurse examines the resident. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's physician orders revealed an order dated 8/5/25, that indicated resident may transfer and ambulate (move about) with supervision. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/24/25, indicated diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), depression, and difficulty swallowing. Review of Resident R1's progress note dated 8/24/25, at 10:35 a.m. stated the following: Called to evaluate resident. History of fall on 8/19/25 with no apparent injury. Resident found in bed, appeared to be in pain. On evaluation, left leg had very significant swelling along entire femur (upper leg) area, ecchymosis (bruise) along entire posterior (back) hip and upper femur area that extended into groin, external rotation, and shortening. Positive pain response (yell out and grimace) to palpation (touching) of femur and hip, and with attempts to log roll. Resident unable to do any bed mobility on his own. Resident medicated for pain with Tylenol (a pain reliever) and call placed to doctor. Resident to have hospice evaluation tomorrow for general decline. Per staff, he was able to stand and pivot on both [NAME] (lower extremities- legs) yesterday. Review of Resident R1's progress note dated 8/24/25, at 7:37 p.m. stated Call placed to hospital, patient was admitted with left hip fracture. Review of a written statement from Licensed Practical Nurse (LPN) Employee E1 dated 8/24/25, stated This LPN removed resident's BLE (bilateral lower extremities (both legs) ACE wraps (an elastic compression bandage) around 7:00- 7:15 p.m. [on 8/23/25] while resident's family was visiting. BLE were at baseline for resident. No pain noted. After family left Nurse Aide (NA) Employee E2, and NA Employee E3 put resident in bed. This LPN was not made aware of any falls or anything. Review of a written statement from NA Employee E4 dated 8/24/25, stated While providing morning care, I noticed his [Resident R1] leg was turned out and seemingly shorter than the right leg. I began providing peri care (washing anal, and genital areas) and while removing his brief I noticed his left thigh and groin was swollen with bruising to the outer hip, inner thigh, and groin. This occurred at approximately 10:00 a.m. on 8/24/25, and I immediately alerted his nurse. Review of a written statement from Registered Nurse (RN) Supervisor Employee E5 dated 8/24/25, stated This nurse asked Nurse Aide (NA) Employee E2 about the incident that occurred on 3 pm to 11 pm shift on 8/23/25. At that time NA Employee E2 stated 'I need to tell you the truth'. NA Employee E2 stated that she, and NA Employee E3 were transferring Resident R1 into bed [from the wheelchair], and they had to lower him to the ground. I asked how hard he hit the ground and she said it was a little harder on NA Employee E2's side than her side. I asked if she notified the nurse. She said they talked and decided not to let the nurse know. When I asked how the resident got up, she said that NA Employee E2 went and got NA Employee E6 to help. When I asked NA Employee E2 if NA Employee E6 was aware that the nurse didn't know about the incident, she told me he was not aware. When I asked if she noticed any bruising or anything after, she said she did not. Educated her that any change of plane for a resident is an incident that the nurse needs to be aware of. Review of a written statement from NA Employee E2 dated 8/24/25, stated on 8/22/25, Resident R1 displayed signs of unable to stand steadily. On 8/23/25, prior to 8:00 p.m. I asked NA Employee E3 to help me assist resident into bed. NA Employee E2 was unable to hold resident's weight on her side, and the resident began to drop towards the floor. I still had a hold of resident under his right arm, his pants, and resident was resting on my right leg. NA Employee E3 was unable to pick him up from the position. I was holding his weight and was unable to lift up. I told her to lower him to the floor since we were unable to place him back into his chair and unable to pivot and place him in the bed. We lowered him to the floor. NA Employee E3 left to get someone to assist us to pick him up and returned with NA Employee E6 who helped</p> | | |