STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395164	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Specialty Care Center	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 - 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 policy and documentation, staff and resident interviews it was determined that the facility failed to protect residents from neglect which resulted in actual harm of multi-system trauma for one of three residents (Resident R1) and transfer to a trauma center hospital.Findings include:Review of facility policy Abuse, Prevention of Resident Abuse, Neglect, Mental Abuse, Reports of Theft, 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, and misappropriation of resident property.Review of the facility policy Transportation-Competencies and Monitoring dated 8/18/25, indicated all drivers will perform and pass competencies in the following areas: Q-Straint Wheelchair Securement (straps and buckle system that secures wheelchair in wheelchair van), van lift operation, driver responsibilities while escorting a resident, and safe operation of vehicle.Review of the clinical 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 1/15/26, indicated diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section C0500 Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of 15, cognitively intact.Review of Resident R1's progress note dated 1/20/26, at 2:37 p.m. indicated resident was on the way to an appointment in the wheelchair van. Per resident's statement the van was taking a left-hand turn when the wheelchair tipped over and resident landed on their right side. Resident believes they hit their head on the door of the wheelchair van. Resident was assisted out of the van and back to the bed. Resident complained of significant pain to the right shoulder, right hip, had a small hematoma (a localized collection of clotted or partially clotted blood outside blood vessels, caused by damaged vessel walls from trauma) above the right ear, and hematoma on the right ear. Unable to assess right hip and right shoulder for bruising while in bed due to pain with movement trying to remove clothing. Resident is on Lovenox (blood thinner). Orders received to transfer to the emergency room. Brother present and made aware of transfer orders.Review of the hospital documentation dated 1/20/26, indicated resident was in a wheelchair van and resident stated they were not secure in the chair. The chair was secure in the van. The wheelchair went around the bend, and it tipped and collapsed on the resident making the resident fall. Complaints of right shoulder and right hip pain that struck the side of the van. Resident also struck their head.Injuries: 1. Non-displaced right transverse process fracture of the seventh cervical vertebra of the spine (C7). 2. Acute right transverse process fracture of the second thoracic vertebra of the spine (T2). 3. Fractures of the first, second, third, and fourth right ribs. 4. Fracture of right clavicle (collar bone) with questionable extension into the joint. 5. Non-displaced fracture of the posterior inferior right pubic ramus (part of lower (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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(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	pelvic bone). 6. Acute comminuted (severe injury where a bone breaks into three or more pieces) fracture of the anterior right hip acetabulum (socket of hip). 7. Questionable fracture of right lateral sacrum (base of the spine that forms the back wall of the pelvis).emergency room physician at local hospital discussed resident's case with Trauma Hospital physician at another hospital reporting multi-system trauma from fall in a wheelchair van while going around a bend. The trauma level hospital accepted the care of resident and ordered transfer for further treatment.Review of facility provided documentation dated 1/20/26, indicated Incident: resident fall with injury during wheelchair van transport due to failure to apply passenger seatbelt.Review of Driver Employee E1's orientation and competency documentation dated 9/2/25, indicated the Q-straint securement system training was provided and Driver Employee E1's signature and date of 9/2/25, was on the document.Review of Driver Employee E1's signed witness statement dated 1/20/26, indicated they turned left in a wide and slow turn, the wheelchair collapsed and went to the right. The resident fell off wheelchair onto the floor of the van. The wheelchair seemed flimsy when the driver strapped the lower bars in at all four points.Review of Resident R1's signed witness statement dated 1/20/26, indicated the driver did not fasten a belt around their chest.Interview with Maintenance Manager Employee E2, on 2/11/26, at 11:31 a.m. indicated the Q-Straint system is a five-point system, four connect to the actual wheelchair and then there is a chest lap harness almost like a regular seat belt, as the fifth point. The following day I examined the van and all the parts and belts were intact and functioning. The resident said that the final seatbelt strap was not connected correctly, and if it had been resident would not have suffered a fall. Interview on 2/11/26, at 1:45 p.m. Resident R1 indicated the wheelchair was strapped into the floor but Driver Employee E1 never put the chest lap harness on. When we went around the bend in the van, the chair tipped over and resident fell to the wheelchair van's floor on the right side.Interview on 2/11/26, at 11:45 a.m. the Nursing Home Administrator indicated the Driver Employee E1 was terminated for neglecting to use the Q-Straint appropriately at all five points as required.During an interview on 2/11/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to protect Resident R1 from neglect when staff failed to properly secure resident in wheelchair van resulting in actual harm of multi-system trauma for one of three residents (Resident R1) and transfer to a trauma center hospital.28 Pa. Code: 201.14(a) Responsibility of licensee28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) 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 facility policy, resident clinical records, facility provided documents, reports submitted to the State, and staff interview it was determined that the facility failed to report an allegation of abuse for one of three residents (Resident R2).Findings include:Review of facility policy Abuse, Neglect, Misappropriation, and Exploitation Reporting dated 8/18/25, indicated all incidents of actual, alleged, or suspected abuse, neglect, theft, misappropriation of residents' property or injury of unknown origin will be promptly reported and thoroughly investigated.Review of the admission record indicated Resident R4 was admitted to the facility on [DATE].Review of Resident R2's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/1/26, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section C0500 Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of 99 resident was unable to complete the interview.Review of facility provided documents dated 12/30/35, indicated two staff members reported to the Director of Nursing that they overheard Nurse Aide (NA) Employee E3 yelling at Resident R2. Two statements indicated NA Employee 3 was yelling and swearing at Resident R2. NA Employee E5 indicated they informed NA Employee E3 that they could not speak to the resident like that.Review of Licensed Practical Nurse (LPN) Employee E4's signed witness statement dated 12/30/25, indicated they were getting ready to enter Resident R2's room when they heard NA Employee E3 say to Resident R2 I can't stand you f*cking yelling like that. NA Employee E5 said to NA Employee E3 you can't speak to the resident like that. NA Employee E3 kept responding I don't care, I can't f*cking stand you yelling like that.Review of NA Employee E5's signed witness statement dated 12/30/25, indicated they were assisting NA Employee E3 with taking Resident R2 off the toilet, NA Employee E3 kept saying I don't care, I can't f*cking stand you yelling like that.Interview on 2/11/26, at 1:57 p.m. LPN Employee E4 indicated I remember NA Employee E3 was getting Resident R2 up and ready for the day, as I was entering the room NA Employee E3 verbalized I can't f*cking stand you yelling. NA Employee E5 told NA Employee E3 not to talk to the residents like that and NA Employee E3 walked away scoffing. We both reported it to the Director of Nursing.Interview on 2/11/26, at 2:10 p.m. NA Employee E5 indicated NA Employee E3 yelled at Resident R2 saying I can't stand you f*cking yelling like that. I told NA Employee E3 you can't talk to the residents like that and NA Employee E3 kept saying I don't care. We both reported it to the Director of Nursing. Administration called up to the unit to remove NA Employee E3 from the unit.Interview on 2/11/26, at 2:30 p.m. the Director of Nursing indicated the facility had an investigation; however, chose not to report it to the Department of Health as required because she didn't feel it was threatening in nature.Interview on 2/11/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to report an allegation of abuse for one of three residents (Resident R2).28 Pa Code: 201.14 (a)(c)(e) Responsibility of management28 Pa Code: 201.18 (b)(1) (e)(1) Management.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to make certain that each resident received adequate supervision and assistance to prevent accidents which resulted in actual harm of multi-system trauma for one of three residents (Resident R1) and transfer to a trauma center hospital. Findings include: Review of the facility policy Resident Accidents/Incidents dated 8/18/25, indicated the facility will provide a safe and secure environment for residents and will be proactive in the prevention of accidents and incidents.Review of the facility policy Reporting a Resident Incident During Transport dated 1/2026, indicated all drivers operating company vehicles will do so in a cautious and careful manner with the safety and well-being of the residents in mind at all times.Review of the clinical 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 1/15/26, indicated diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section C0500 Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of 15, cognitively intact.Review of Resident R1's progress note dated 1/20/26, at 2:37 p.m. indicated resident was on the way to an appointment in the wheelchair van. Per resident's statement the van was taking a left-hand turn when the wheelchair tipped over and resident landed on their right side. Resident believes they hit their head on the door of the wheelchair van. Resident was assisted out of the van and back to the bed. Resident complained of significant pain to the right shoulder, right hip, had a small hematoma (a localized collection of clotted or partially clotted blood outside blood vessels, caused by damaged vessel walls from trauma) above the right ear, and hematoma on the right ear. Unable to assess right hip and right shoulder for bruising while in bed due to pain with movement trying to remove clothing. Resident is on Lovenox (blood thinner). Orders received to transfer to the emergency room. Brother present and made aware of transfer orders.Review of the hospital documentation dated 1/20/26, indicated resident was in a wheelchair van and resident stated they were not secure in the chair. The chair was secure in the van. The wheelchair went around the bend, and it tipped and collapsed on the resident making the resident fall. Complaints of right shoulder and right hip pain that struck the side of the van. Resident also struck their head.Injuries: 1. Non-displaced right transverse process fracture of the seventh cervical vertebra of the spine (C7). 2. Acute right transverse process fracture of the second thoracic vertebra of the spine (T2). 3. Fractures of the first, second, third, and fourth right ribs. 4. Fracture of right clavicle (collar bone) with questionable extension into the joint. 5. Non-displaced fracture of the posterior inferior right pubic ramus (part of lower pelvic bone). 6. Acute comminuted (severe injury where a bone breaks into three or more pieces) fracture of the anterior right hip acetabulum (socket of hip). 7. Questionable fracture of right lateral sacrum (base of the spine that forms the back wall of the pelvis).emergency room physician at local hospital discussed resident's case with Trauma Hospital physician at another hospital reporting multi-system trauma from fall in a wheelchair van while going around a bend. The trauma level hospital accepted the care of resident and ordered transfer for further treatment.Review of facility provided documentation dated 1/20/26, indicated Incident: resident fall with injury during wheelchair van transport due to failure to apply passenger seatbelt.Review of Resident R1's signed witness statement dated 1/20/26, indicated the driver did not fasten a belt around their chest.Interview with Maintenance Manager Employee E2, on 2/11/26, at 11:31 a.m. indicated the Q-Straint system is a five-point (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	system, four connect to the actual wheelchair and then there is a chest lap harness almost like a regular seat belt, as the fifth point. The following day the van was examined, and all the parts and belts were intact and functioning. The resident said that the final seatbelt strap was not connected correctly, and if it had been resident would not have suffered a fall. Interview on 2/11/26, at 1:45 p.m. Resident R1 indicated the wheelchair was strapped into the floor but Driver Employee E1 never put the chest lap harness on. When we went around the bend in the van, the chair tipped over and resident fell to the wheelchair van's floor on the right side.During an interview on 2/11/26, at 3:00 p.m. the Nursing Home Administrator confirmed at the facility failed to make certain that each resident received adequate supervision and assistance to prevent accidents which resulted in actual harm of a multi-system trauma for one of three residents (Resident R1) and transfer to a trauma center hospital. 28 Pa. Code 201.14 Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29 Responsibility of Licensee.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.28 Pa. Code 211.10(d) Resident care policies.