STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395200	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Nursing and Rehab	4850 Zuck Road Erie, PA 16506

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, clinical records, and facility documentation; and staff interview, it was determined that the facility failed to provide services to create an environment free from neglect by transferring a resident improperly, resulting in actual harm when the resident suffered an unsurvivable subdural hematoma (type of brain bleed in which the blood pools between the skull and the brain and is usually caused by head trauma) that required medical treatment at a hospital for one of three residents reviewed (Closed Record Resident CR17). This deficiency is cited as past non-compliance. Findings include: A facility policy entitled Lifting Machine, Using a Mechanical dated 1/12/26, indicated:At least two nursing assistants are needed to safely move a resident with a mechanical lift.Before using a lifting device, assess the resident's current condition, including;Can the resident assist with transfer?Is the resident's weight and medical condition appropriate for the use of a lift?Can the resident understand and follow instructions? A facility policy entitled Abuse Prevention Program dated 1/12/26, indicated:Residents have the right to be free from abuse and neglect.The administration will:Protect our residents from abuse by anyone including staff from other agencies.Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents.Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting abuse, stress management, and handling verbally or physically aggressive resident behavior. Resident CR17's clinical record revealed an admission date of 3/01/25, with diagnoses including chronic obstructive pulmonary disease (term for lung and airway diseases that restrict your breathing), dementia, presence of left artificial hip joint, and stroke. A Quarterly Minimum Data Set (standardized tool used in nursing homes to evaluate residents' health, functional status, and care needs) dated 5/08/26, Section C-Cognitive Patterns item C0500 indicated Closed Record Resident CR17's Brief Interview for Mental Status (BIMS [structured interview for elderly patients to assess attention, orientation and recall]) indicated he/she scored a seven (severe cognitive impairment). Resident CR17's Kardex (place in a resident's record for care instructions) indicated that he/she was to be transferred from chair/bed-to-chair with moderate assistance of two people. Physical Therapy Discharge summary dated [DATE], indicated that Resident CR17 required maximum assistance for transfers. Resident CR17's Task List Report resolved on 6/01/26, indicated that he/she should be transferred from chair/bed-to-chair with moderate assistance of two staff. Resident CR17's departmental progress notes revealed:5/29/26, documented by the Registered Nurse (RN) Supervisor revealed he/she was called to Resident CR17's room at approximately 8:35 p.m. by the Nurse Aide (NA) to discover Resident CR17 lying on the floor next to the bed. Statements made by Resident CR17 at that time confirmed that he/she had fallen. The physical assessment revealed a three-centimeter by three-centimeter bruise and a small scrape on the back of the head.5/29/26, at 11:20 p.m. departmental progress notes revealed Resident CR17 reported right arm discomfort.5/30/26, at 12:15 a.m. revealed the Licensed Practical Nurse (LPN) was informed by the NA that Resident CR17 fell and hit his/her head. The LPN responded to the room immediately and Resident CR17 reported that he/she fell during transfer and hit his/her head, and (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	reported pain to the back of the head.5/30/26, at 1:39 a.m. indicated that Resident CR17 was transferred to the hospital following a fall and change in mental status.5/30/26, at 1:50 a.m. revealed that at approximately 1:30 a.m. the NA reported to the RN Supervisor that Resident CR17 was not responding normally and was shaking a little bit. Resident CR17 was non-verbal and had left-sided body tremors.5/30/26, at 3:00 a.m. facility staff received a call from the hospital that Resident CR17 had a non-survivable bleed and that he/she was returning to the facility on comfort measures.5/30/26, at 11:28 a.m. provider assessment note revealed that upon arrival at the hospital he/she was a level 1 trauma (highest level of trauma care, provided to patients with life-threatening injuries) and a [NAME] Coma Scale of 8 (severe brain injury).5/31/26, 11:08 a.m. revealed rattling, shortness of breath and labored breathing. Ordered Morphine.5/31/26, at 12:26 p.m. family at bedside.6/01/26, at 7:00 a.m. rapid breathing, eye twitching.6/01/26, at 7:55 a.m. white foam coming from the mouth, resident ceased to breathe.Review of Resident CR17's hospital records dated 5/30/26, revealed that he/she presented to the emergency department following a fall and was found to have an unsurvivable subdural hematoma.Review of the facility incident investigation revealed:A witness statement dated 5/29/26, for 8:30 p.m. obtained from agency NA Employee E1stated that he/she transferred Resident CR17 via a stand lift, and that prior to and during the transfer, the resident released his/her hands from the bars despite verbal cues to maintain his/her grip. The resident subsequently lost support and fell from the stand lift.A witness statement dated 6/01/26, for 4:24 p.m. obtained from LPN Employee E2 stated that immediately following the incident, with the assistance of another NA, was able to immediately locate the transfer status of Resident CR17 on the Point of Care (mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation).During an interview on 6/23/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that after the investigation was completed, it was discovered that agency NA Employee E1 had transferred Resident CR17 with a stand lift and that the resident's transfer status was moderate assistance from two staff.The facility failed to ensure that Resident CR17 was free from abuse resulting in actual harm of a subdural hematoma from an improper transfer without the required two-person moderate assistance.This deficiency is cited as past non-compliance.On 6/23/26, the facility submitted a plan to include:The agency NA Employee E1 was removed from the schedule and would not be returning.The Director of Maintenance impacted the stand lift involved in the incident and determined proper operating function.The facility initiated re-educating all staff prior to their next shift on the location of medical records and location of transfer status; mechanical lift operation; and abuse/neglect/exploitation.The Director of therapy completed whole house audits of all resident's transfer statuses.The Director of Nursing initiated transfer audits five days a week for two weeks, then monthly until substantial compliance is met.Interviews on 6/23/26, between 11:30 a.m. and 1:00 p.m. with LPN Employee E5, NA Employee E6, NA Employee E7, NA Employee E8, NA Employee E9, LPN Employee E10, and RN Employee E11 confirmed they were educated on locating resident's current transfer status on the Point of Care Kiosk, the abuse policy, and the mechanical lift policy. Review of facility staff education revealed the education was completed on 6/12/26. Facility transfers review audits revealed achieved compliance on 6/17/26 and the facility will continue with audits to ensure staff compliance.28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services