STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395249	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48276 Based on observation and staff interviews, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, and orderly environment in one of the three resident units (C Hall). Findings include: An observation on, July 2, 2024, at 8:22 AM of the wall at the C Hall nursing station revealed an area of missing floor strip molding that created a hole measuring 3 inches x 24 inches. An accummulation of rocks, dirt, metal, and other debris were observed on the floor near this hole. An ethernet outlet cover was detached from the wall, exposing the interior wiring. A small cut was observed the protective plastic exterior of a black phone wire, and an unused white phone wire was hanging from the wall. An observation on July 2, 2024, at 8:27 AM revealed dead bugs and debris inside the ceiling light fixture in the C Hall resident shower room. A thick layer of brown and gray dust was observed covering the ceiling vent and internal fan blades. An observation on July 2, 2024, at 8:32 AM in resident room C-16 revealed the floor molding was peeling from the wall, exposing a dark discoloration on the wall. A banana peel, plastic wrapping, food wrapper, and white paper were observed on the floor next to the window-bed An observation on July 2, 2024, at 8:36 AM in resident room C-3 revealed the strip molding on the floor of resident bathroom was peeling away from the wall and surrounding discolored stains. Dirt and debris was observed on the bathroom floor. An observation on July 2, 2024, at 8:38 AM in resident room C-13 revealed a clear plastic medicine cup, white paper, and a red food wrapper on the floor near the wall by the window. [NAME] wrapper, brown paper, dirt, and debris was observed on the floor of the resident bathroom. An observation on July 2, 2024, at 8:41 AM in resident room C-9 revealed the name identification plate was missing and discoloration was observed where the identification fixture had been located. An observation on July 2, 2024, at 8:43 AM in resident room C-9 revealed black dirt and debris on the bathroom floor. The toilet in the resident bathroom was observed continuously running. (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: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on July 2, 2024, at 8:59 AM in resident room C-17 revealed the pipe under the bathroom sink was leaking when the sink faucet was running. An observation on July 2, 2024, at 10:24 AM in the resident lounge revealed a blue resident lift-to-stand device with discolored white medical tape covering the left arm rest. The tape was frayed and peeling from the chair. An interview with the Nursing Home Administrator and Director of Nursing on July 2, 2024, at 1:00 PM confirmed that the environment and care equipment should be maintained in a safe, clean, and orderly manner. 28 Pa Code 201.18 (e)(2.1) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy and investigative reports, and staff interviews, it was determined that the facility failed to ensure that one resident out of 15 sampled was free from verbal and mental abuse (Resident A1). Findings include: A facility policy titled Abuse, dated as reviewed by the facility April 17, 2024, revealed that that it is the facility policy that each resident will be free from abuse. Abuse can include verbal and mental abuse. The facility policy defines verbal abuse as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he will never be able to see his family again. Mental abuse was defined as the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Examples of mental and verbal abuse include, but are not limited to: harassing a resident; mocking, insulting, and ridiculing; yelling or hovering over a resident with the intent to intimidate; and threatening residents. A clinical record review revealed Resident A1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a condition when at least five joints are affected by inflammation) and bilateral below-knee leg amputations. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 31, 2024 revealed that Resident A1 is cognitively intact with a BIMS score of 15 (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 13-15 indicates cognition is intact). A witness statement dated June 18, 2024, revealed that Resident A1 was re-interviewed in response to an allegation of verbal abuse by Employee 3 that occurred on June 8, 2024. Resident A1 reported that he had an argument with Employee 3, Nurse Aide (NA). Resident A1 indicated that Employee 3, told the resident I'll drag your no-leg ass out that chair and I'm the one who comes in your room every day while you're sleeping, you could wake up dead. A review of a witness statement dated June 18, 2024, provided by Employee 3, NA, indicated that on June 8, 2024, Resident A1 approached her outside the nursing station and stated that he did not want her to bring water, food, or anything into his room. Employee 3, NA, indicated that Resident A1 threatened her. Employee 3, NA, stated, I was very upset with him threatening me. If I said things inappropriate, I really don't remember. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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	A review of a witness statement dated June 18, 2024, provided by Employee 5, NA, revealed that on June 8, 2024, she heard Employee 3 and Resident A1 arguing around 4:00 AM. Employee 5, NA, explained that the argument was going on for a few minutes when she walked toward the altercation. Employee 5 stated that they were calling each other names, cursing, and hollering. Employee 5, relayed that she saw Employee 4, Registered Nurse (RN), standing in front of Employee 3 with her arms extended, blocking her from getting to Resident A1. Employee 5, stated that she heard Employee 3 call Resident A1 a grimy mother f*cker, get the f*ck out of here, by the time I'm finished with you, I'll make sure your no leg ass will be out of this motherf*cker, and accused the resident of stealing. A review of a witness statement dated June 19, 2024, provided by Employee 4, RN, indicated that on June 8, 2024, while on duty, his attention was drawn to a resident and caregiver (Employee 3, NA) having an altercation. He stated that he did see Resident A1 and Employee 3, NA, in close proximity to each other, exchanging abusive language. Employee 4, RN, explained that he heard Employee 3 say words like legless man and that Resident A1 should do something about it. Employee 4, RN, indicated that he removed Employee 3 from the scene. Additionally, Employee 4, RN, stated that he took statements from both parties. A review of a witness statement dated June 19, 2024, provided by Employee 6, RN, indicated that on {June 8, 2024} she observed Employee 3 and Resident A1 yelling at each other. Employee 6, RN, stated that both the resident and staff member, Employee 3, were using profanities. A facility investigation dated June 20, 2024, concluded that Employee 3, NA, made statements to Resident A1 that met the requirements for mental abuse and the employee was terminated from employment at the facility During an interview on July 2, 2024, at 9:00 AM, Resident A1 stated that a few weeks ago, {on June 8, 2024}, he confronted Employee 3, a nurse aide, outside the nursing station with witnesses present. He explained that he wanted to tell Employee 3 that he did not want her to come into his room or provide him with care. He explained that the conversation turned into an argument. Resident A1 stated that during their argument, the nursing supervisor {Employee 4, RN} held Employee 3, back and moved her towards the nursing station. Resident A1 stated that he cursed at Employee 3, and Employee 3 stated, You are the one in the room sleeping, you will end up dead. During an interview on July 2, 2024, at 11:45 AM, Employee 5, a nurse aide, confirmed that she heard Employee 3, nurse aide, and Resident A1 in an argument outside the C Hall Nursing Station on June 8, 2024, at about 4:00 AM. Employee 5, stated that she saw Employee 3 aggressively slapping her chest and heard her say, I'll drag your no-legged ass out of this motherf*cker. Employee 5, stated that Employee 4, RN, got in between Resident A1 and Employee 3 to prevent Employee 3 from getting closer to Resident A1. Employee 5 also stated that even as Resident A1 was heading back to his room, she recalled that Employee 3 continued to yell at him. During an interview on July 2, 2024, at 12:00 PM, Employee 4, RN, confirmed that he witnessed and intervened during an altercation on June 8, 2024, between Employee 3 and Resident A1. Employee 4, RN, stated that Employee 3 was yelling phrases like double amputee, do something about it. Employee 4, RN, explained that he held Employee 3, NA, by the shoulders to prevent her from getting closer to Resident A1 and removed her from the scene. Employee 4, RN, stated that it took some time to get Employee 3 away from Resident A1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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	During an interview on July 2, 2024, at approximately 1:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) stated that the facility failed to protect Resident A1 from verbal and mental abuse, including insults, yelling, and threats. The DON and NHA confirmed that Employee 3, NA, was suspended from the facility on June 15, 2024, and terminated on June 20, 2024, for verbally and mentally abusing Resident A1. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 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 48276

Based on a review of clinical records, the facility's abuse prohibition policy, facility investigation reports, and resident and staff interviews, it was determined the facility failed to timely report the witnessed abuse of one resident out of 15 sampled (Resident A1) to the State Survey Agency.

Findings include:

A facility policy titled Abuse, dated as reviewed by the facility on April 17, 2024, indicated that abuse allegations are reported per federal and state law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency. Employees must always report any abuse or suspicion of abuse immediately to the administrator. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he will never be able to see his family again. Mental abuse is defined as the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Examples of mental and verbal abuse include, but are not limited to: harassing a resident; mocking, insulting, and ridiculing; yelling or hovering over a resident with the intent to intimidate; and threatening residents.

A clinical record review revealed Resident A1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a condition when at least five joints are affected by inflammation) and bilateral below-knee leg amputations.

A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 31, 2024 revealed that Resident A1 is cognitively intact with a BIMS score of 15 (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 13-15 indicates cognition is intact).

A facility investigation dated as initiated on June 15, 2024, indicated that on June 8, 2024, Employee 3, Nurse Aide (NA), made threatening and derogatory statements to Resident A1 that met the definition of mental and verbal abuse and was subsequently terminated from employment on June 20, 2024.

A witness statement provided by Employee 7, Licensed Practical Nurse (LPN), indicated that on June 15, 2024, Employee 3, Nurse Aide (NA), was upset that people could call residents names and {continue to work at the facility}. Employee 5 explained that she witnessed Employee 3, NA, call Resident A1 no good filthy mother f*cker and that the registered nurse had to intervene and hold Employee 3, NA, back {from Resident A1} on June 8, 2024.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 2, 2024, at 9:00 AM, Resident A1 stated that a few weeks ago, {on June 8, 2024}, he confronted Employee 3, NA, outside the nursing station with witnesses present. He stated that he wanted to tell Employee 3 that he did not want her to come into his room or provide him with care. He explained that the conversation turned into an argument. Resident A1 stated that he cursed at Employee 3, and Employee 3 said in response, You are the one in the room sleeping; you will end up dead. Resident A1 indicated that during their argument, the nursing supervisor {Employee 4, RN} held Employee 3, NA, back and moved her towards the nursing station. During an interview on July 2, 2024, at 11:45 AM, Employee 5, NA, confirmed that she heard Employee 3, and Resident A1 in an argument outside the C Hall Nursing Station on June 8, 2024, at about 4:00 AM. Employee 5, stated that she saw Employee 5, NA, aggressively slapping her chest and heard her say, I'll drag your no-legged ass out of this motherf*cker. Employee 5, NA, stated that Employee 4, RN, got in between Resident A1 and Employee 3 to prevent Employee 3 from getting closer to Resident A1. Employee 5 also stated that even as Resident A1 was heading back to his room, she recalled that Employee 3 continued to yell at him. Employee 5, NA, stated that no one from the facility had interviewed her about the incident or asked her to write a statement until June 15, 2024, when she reported that she was upset that the incident was not addressed by the facility's administration. During an interview on July 2, 2024, at 12:00 PM, Employee 4, Registered Nurse (RN), confirmed that he witnessed and intervened during an altercation on June 8, 2024, between Employee 3, NA, and Resident A1. Employee 4, RN, stated that Employee 3 was yelling phrases like double amputee, do something about it. Employee 4, RN, explained that he held Employee 3, NA, by the shoulders to prevent her from getting closer to Resident A1 and removed her from the scene. Employee 4, RN, stated that it took some time to get Employee 3 away from Resident A1. Employee 4, RN, explained that following the incident, he wrote a statement, collected statements from other staff present, and contacted administration. He stated that he submitted the statements he collected to the facility administration on June 8, 2024. Employee 4, RN, stated that Employee 3, NA, was assigned to a different resident hall and continued to work with residents for the remainder of that shift on June 8, 2024, following the witnessed verbal and mental abuse of Resident A1. During an interview on July 2, 2024, at approximately 1:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that the facility did not report the allegations that Employee 3, NA, had verbally and mentally abused Resident A1 on June 8, 2024, to the State Survey Agency within 24 hours of the witnessed abuse. The NHA and DON confirmed that the facility did not report the abuse until seven days after the incident on June 15, 2024. The NHA and DON were unable to provide the surveyor the statements Employee 4, RN, stated that he submitted to facility administration on June 8, 2024. The DON and NHA confirmed that Employee 3, NA, was not suspended from the facility, and continued to work with residents, until June 15, 2024. Employee 3 was terminated on June 20, 2024, for verbally and mentally abusing Resident A1. Refer F600 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility incident reports and the facility's abuse prohibition policy and resident and staff interviews, it was determined that the facility failed to timely and thoroughly investigate an injury of unknown source to rule out abuse, neglect or mistreatment for one of 15 residents sampled (Resident CR1) and failed to promptly conduct a thorough investigation into the witnessed abuse perpetrated by Employee 3, and failed to protect residents from the potential for further abuse during the course of the investigation into the abuse of one resident (Resident A1) out of the 15 sampled residents. The findings include: A review of the facility's Abuse Prohibition Policy last reviewed [DATE], indicated that the objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detention and prevention. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. Mental abuse is defined as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Injuries of Unknown Origin include that the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. It is the policy of this facility that reports of abuse are promptly and thoroughly investigated. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. Employees accused of abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation. A review of Resident CR1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease and osteopenia (reduced bone density which can make bones weaker and increases risk for fracture). Resident CR1 was placed on Hospice on [DATE]. Resident CR1 expired at the facility on [DATE]. Review of Resident C1's significant change Minimum Data Set (MDS - federally mandated standardized assessment process completed periodically to plan resident care), dated [DATE], indicated the resident was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 9 (a score of 8- 12 indicates moderately impaired), displayed physical and verbal behaviors, and required two plus persons physical assistance for bed mobility and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurses note dated [DATE], at 9:42 AM revealed Employee 1 (RN Unit Manager) was called to Resident C1's room by Employee 2 (nurse aide). The resident's left lower shin appeared to be freely moving, not warm to touch, no redness noted, and resident was grimacing and yelling in pain. As needed Tylenol given as ordered. Call to CRNP (certified registered nurse practitioner) with order for STAT x-ray to left lower extremity. A nurses note dated [DATE], at 10:54 AM indicated that the x-ray was completed and the resident had a tibia-fibula fracture (broken bones in the lower leg). Call to CRNP. Physician order to transfer resident to emergency room . Resident Representative aware. A nurses note dated [DATE], at 12:29 PM indicated that a call was received from the emergency room physician reporting that the resident has obvious fracture but is not a surgical candidate. A nurses note dated [DATE], at 8:29 PM indicated that the resident returned from the emergency room with splint on the left leg. Review of Resident CR1's Documentation Survey Report for [DATE] revealed that on [DATE], on the 11:00 PM shift to 7:00 AM shift the resident was dependent for bed mobility and required the assistance of two staff and for toileting the resident required assist times two staff with a passive lift (full mechanical lift). At 2:16 AM (on [DATE], prior to finding Resident CR1's fracture) Employee 3 (nurse aide) signed off that only one staff member was used for bed mobility and at 2:14 AM and signed off only one staff member was used for toileting the resident. Review of Employee 3 (nurse aide) witness statement dated [DATE], regarding the injury revealed that she did not notice anything with the resident's legs and that the resident was already in bed, was not transferred and did not scream out or anything. Further review of the witness statement revealed no documented evidence of any care she provided to the resident despite the employee signing off on the resident's Documentation Survey Report as to providing bed mobility and toileting of the resident on that shift. Review of the facility's Incident Report dated [DATE], and concluded [DATE], indicated that per statements and nurses notes the resident had displayed behaviors such as removing clothes, yelling, agitation, hitting, the wall, leaning over Broda chair (wheelchair which can tilt and recline), grabbing at staff. The interdisciplinary team concluded that the resident's behaviors along with diagnosis of osteopenia could have contributed to the leg fracture. The facility failed to identify that Employee 3 documented providing care to the resident during the prior shift, without the assistance of another person. However, further review of the Employee 3's (nurse aide) witness statement failed to indicate what care she provided for the resident during the shift related to her signing the resident's Documentation Survey Report indicating that only one staff member was used for assisting the resident with bed mobility at 2:16 AM on [DATE]. The facility failed to implement its established procedures in response to an injury of unknown origin, a fracture, by failing to conduct a thorough investigation to rule out potential abuse, neglect, or mistreatment of the resident as a potential cause of this serious injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator (NHA) on [DATE], at approximately 1:00 PM confirmed that the facility could not provide documented evidence that the facility fully investigated Resident CR1's injury of unknown origin (left tibia/fibula fracture). A clinical record review revealed Resident A1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a condition when at least five joints are affected by inflammation) and bilateral below-knee leg amputations. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated [DATE] revealed that Resident A1 is cognitively intact with a BIMS score of 15 (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 ,d+[DATE] indicates cognition is intact). A facility investigation dated as initiated on [DATE], indicated that on [DATE], Employee 3, Nurse Aide (NA), was observed to make threatening and derogatory statements to Resident A1 that met the definition of mental and verbal abuse and was eventually terminated from employment on [DATE]. A witness statement provided by Employee 7, Licensed Practical Nurse (LPN), dated [DATE], revealed that this employee was upset that people could call residents names and {continue to work at the facility}. Employee 5 explained that she witnessed Employee 3, NA, call Resident A1 no good filthy mother f*cker and that the registered nurse had to intervene and hold Employee 3, NA, back {from Resident A1} on [DATE]. During an interview on [DATE], at 9:00 AM, Resident A1 stated that a few weeks ago, {on [DATE]}, he confronted Employee 3, NA, outside the nursing station with witnesses present. He explained that he wanted to tell Employee 3 that he did not want her to come into his room or provide him with care. He explained that the conversation turned into an argument. Resident A1 stated that he cursed at Employee 3, and Employee 3 said in response, You are the one in the room sleeping; you will end up dead. Resident A1 stated that during their argument, the nursing supervisor {Employee 4, RN} held Employee 3, NA back and moved her back towards the nursing station. Resident A1 stated that for about a week following the altercation, Employee 3 continued to work at the facility and even came into his room to deliver food and water to his roommate. Resident A1 explained that he would stay up until 1:00 AM on shifts when Employee 3 was working because he believed that she might attempt to hurt him after her threats on [DATE]. During an interview on [DATE], at 11:45 AM, Employee 5, NA, confirmed that she heard Employee 3, NA, and Resident A1 in an argument outside the C Hall Nursing Station on [DATE], at about 4:00 AM. Employee 5, NA, stated that she saw Employee 5, NA, aggressively slapping her chest and heard her say, I'll drag your no-legged ass out of this motherf*cker. Employee 5, stated that Employee 4, RN, got in between Resident A1 and Employee 3 to prevent Employee 3 from getting closer to Resident A1. Employee 5 also stated that even as Resident A1 was heading back to his room, she recalled that Employee 3 continued to yell at him. Employee 5, stated that no one from the facility had interviewed her about her observations of the resident abuse, or asked her to write a statement until [DATE], when she reported that she was upset that the incident was not addressed by the facility administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER: Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 12:00 PM, Employee 4, Registered Nurse (RN), confirmed that he witnessed and intervened during an altercation on [DATE], between Employee 3 and Resident A1. Employee 4, RN, stated that Employee 3 was yelling phrases like double amputee, do something about it. Employee 4, RN, explained that he held Employee 3, NA, by the shoulders to prevent her from getting closer to Resident A1 and remove her from the scene. Employee 4, RN, stated that it took some time to get Employee 3 away from Resident A1. Employee 4, RN, explained that following the incident, he wrote a statement, collected statements from other staff present, and contacted administration. He stated that he submitted the collected statements to the facility administration on [DATE]. Employee 4, RN, stated that after the incident, Employee 3, NA, was assigned to a different resident hall and continued to work with residents for the remainder of that shift. During an interview on [DATE], at approximately 2:00 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) stated that they were unable to locate the {witness} statements Employee 4, RN, had collected and submitted following the witnessed abuse of Resident A1's by Employee 3 on [DATE]. The NHA and DON confirmed that the facility failed to protect Resident A1 and other residents, from the potential for further abuse to be perpetrated by Employee 3. The NHA and DON confirmed that Employee 3, NA, continued to work with residents after the witnessed abuse occurred on [DATE], until Employee 5, NA, reported her concerns to the facility on [DATE]. The DON and NHA confirmed that Employee 3, NA, was not suspended from the facility on [DATE], and terminated on [DATE], for verbally and mentally abusing Resident A1. Refer F600, F609 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 211.12 (c)Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER: Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records, and resident staff interview it was determined that the facility failed to ensure that residents dependent on staff for assistance with activities of daily living consistently were provided showers as planned to maintain good personal hygiene for five of 10 residents sampled (Resident B1, B2, B3, B4, and B5). Findings include: A review of Resident B1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include diabetes, and osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down), A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident B1 dated May 2, 2024, indicated that the resident required substantial/maximal assistance for showering/bathing. The resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates the resident is cognitively intact). During an interview with Resident B1 on July 2, 2024 at 10:10 AM, she reported that staff sometimes don't give me a shower. They don't tell me nothing, they just don't come. I didn't get a shower on Friday (June 28). A review of the June 2024 Documentation Survey Report v2 (care tasks completed for the resident) revealed that the resident was scheduled to be showered on Tuesdays and Fridays, on the dayshift. The Documentation Survey Report v2 dated from June 1, 2024, through June 30, 2024, revealed that Resident B1 did not receive a shower on Friday, June 14 and Friday, June 28, 2024. There was no documented evidence that the resident refused a shower. There was no documented evidence that the facility showered the resident twice each week as planned. There was no documented evidence that the resident refused a shower. A review of Resident B2's clinical record revealed that the resident was admitted to the facility on [DATE] with diagnosis to include Parkinson's disease (a disorder of the central nervous system), and bipolar disorder. A quarterly MDS of Resident B2 dated May 5, 2024, indicated that the resident required supervision/touching assistance for showering/bathing and had a BIMS score of 15. A review of the June 2024 Documentation Survey Report v2 revealed that the resident was scheduled to be showered on Wednesdays and Saturdays, on the evening shift 3 PM to 11 PM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Documentation Survey Report v2 dated from June 1, 2024, through June 30, 2024, revealed that Resident B2 did not receive a shower on Wednesday, June 19 and Saturday, June 22, 2024. There was no documented evidence that the resident refused a shower. There was no documented evidence that the facility showered the resident twice each week as planned. A review of Resident B3's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis to include metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks), and Parkinson's disease. During an interview with Resident B3 on July 2, 2024 at 10:30 AM, he stated that he has not yet been offered a shower since the resident's admission to the facility on [DATE]. A review of the June 2024 Documentation Survey Report v2 revealed that the resident was scheduled to be showered on Wednesdays and Saturdays, on the evening shift 3 PM to 11 PM shift. The Documentation Survey Report v2 dated from June 23, 2024, through June 30, 2024, revealed that Resident B2 did not receive a shower on Wednesday, June 26 and Saturday, June 29, 2024, with staff documenting not applicable as the reason code. There was no documented evidence that the resident refused a shower. There was no documented evidence that the facility showered the resident twice each week as planned. A review of Resident B4's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis to include atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls which causes obstruction of blood flow), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow. A quarterly MDS of Resident B4 dated May 6, 2024, indicated that the resident required substantial/maximal assistance for showering/bathing and had a BIMS score of 15. A review of the June 2024 Documentation Survey Report v2 revealed that the resident was scheduled to be showered on Wednesdays and Saturdays, on the dayshift. The Documentation Survey Report v2 dated from June 1, 2024, through June 30, 2024, revealed that Resident B4 received a bed bath on Saturday, June 1 and Wednesday, June 12, 2024. The resident was not showered on Saturday, June 15 and Wednesday, June 19, 2024. There was no documented evidence that the resident refused a shower. There was no documented evidence that the facility showered the resident twice each week as planned. There was no documented evidence that the resident preferred a bed bath instead of a shower. A review of Resident B5's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis to include cerebrovascular disease (stroke), and diabetes. A quarterly MDS of Resident B5 dated May 24, 2024, indicated that the resident required total assistance from staff for showering/bathing and had a BIMS score of 14. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the June 2024 Documentation Survey Report v2 revealed that the resident was scheduled to be showered on Tuesdays and Fridays, on the evening shift. The Documentation Survey Report v2 dated from June 1, 2024, through June 30, 2024, revealed that Resident B5 received a bed bath on Tuesday, June 4 and Friday, June 7, 2024. She did not receive a shower on Friday, June 21, 2024, with staff documenting not applicable as the reason and was not showered on Tuesday, June 26, 2024. There was no documented evidence that the resident refused a shower. There was no documented evidence that the facility showered the resident twice each week as planned. There was no documented evidence that the resident preferred a bed bath instead of a shower. During interview with the Director of Nursing (DON) on July 2, 2024 at approximately 2:00 PM the DON confirmed that the residents should have been showered as scheduled and was unable to state why the showers were not provided as scheduled and desired by residents. 28 Pa. Code 211.12 (d)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0745

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide medically-related social services to help each resident achieve the highest possible quality of life.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48276

Based on a review of clinical records and select reports and resident and staff interviews it was determined that the facility failed to provide therapeutic social services to a resident following an incident of verbal and mental abuse perpetrated by staff for one resident out of 15 sampled (Resident A1).

Findings included:

According to regulatory requirements under 42 CFR Part 483 Subpart B, the intent of S483.40(d) is to assure that sufficient and appropriate social services are provided to meet the resident's needs.

Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following:

o Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations;

o Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);

o Need for emotional support.

A clinical record review revealed Resident A1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a condition when at least five joints are affected by inflammation) and bilateral below-knee leg amputations.

A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 31, 2024 revealed that Resident A1 is cognitively intact with a BIMS score of 15 (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 13-15 indicates cognition is intact).

A facility investigation dated as initiated on June 15, 2024, indicated that on June 8, 2024, Employee 3, Nurse Aide (NA), was observed to make threatening and derogatory statements to Resident A1 that met the definition of mental and verbal abuse and was eventually terminated from employment on June 20, 2024.

A witness statement provided by Employee 7, Licensed Practical Nurse (LPN), dated June 15, 2024, revealed that this employee was upset that people could call residents names and {continue to work at the facility}. Employee 5 explained that she witnessed Employee 3, NA, call Resident A1 no good filthy mother f*cker and that the registered nurse had to intervene and hold Employee 3, NA, back {from Resident A1} on June 8, 2024.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 2, 2024, at 9:00 AM, Resident A1 stated that a few weeks ago, {on June 8, 2024}, he confronted Employee 3, NA, outside the nursing station with witnesses present. He explained that he wanted to tell Employee 3 that he did not want her to come into his room or provide him with care. He explained that the conversation turned into an argument. Resident A1 stated that he cursed at Employee 3, and Employee 3 said in response, You are the one in the room sleeping; you will end up dead. Resident A1 stated that during their argument, the nursing supervisor {Employee 4, RN} held Employee 3, NA back and moved her back towards the nursing station. Resident A1 stated that for about a week following the altercation, Employee 3 continued to work at the facility and even came into his room to deliver food and water to his roommate. Resident A1 explained that he would stay up until 1:00 AM on shifts when Employee 3 was working because he believed that she might attempt to hurt him after her threats on June 8, 2024. During an interview on July 2, 2024, at 11:45 AM, Employee 5, NA, confirmed that she heard Employee 3, NA, and Resident A1 in an argument outside the C Hall Nursing Station on June 8, 2024, at about 4:00 AM. Employee 5, NA, stated that she saw Employee 5, NA, aggressively slapping her chest and heard her say, I'll drag your no-legged ass out of this motherf*cker. Employee 5, stated that Employee 4, RN, got in between Resident A1 and Employee 3 to prevent Employee 3 from getting closer to Resident A1. Employee 5 also stated that even as Resident A1 was heading back to his room, she recalled that Employee 3 continued to yell at him. Employee 5, stated that no one from the facility had interviewed her about her observations of the resident abuse, or asked her to write a statement until June 15, 2024, when she reported that she was upset that the incident was not addressed by the facility administration. During an interview on July 2, 2024, at 12:00 PM, Employee 4, Registered Nurse (RN), confirmed that he witnessed and intervened during an altercation on June 8, 2024, between Employee 3 and Resident A1. Employee 4, RN, stated that Employee 3 was yelling phrases like double amputee, do something about it. Employee 4, RN, explained that he held Employee 3, NA, by the shoulders to prevent her from getting closer to Resident A1 and remove her from the scene. Employee 4, RN, stated that it took some time to get Employee 3 away from Resident A1. Employee 4, RN, explained that following the incident, he wrote a statement, collected statements from other staff present, and contacted administration. He stated that he submitted the collected statements to the facility administration on June 8, 2024. Employee 4, RN, stated that after the incident, Employee 3, NA, was assigned to a different resident hall and continued to work with residents for the remainder of that shift. A clinical record review revealed no documented evidence that Resident A1 was assessed for any psychosocial harm following the mental and verbal abuse perpetrated by Employee 3 and witnessed by staff on June 8, 2024. During an interview on July 2, 2024, at 1:50 PM, the Director of Social Services confirmed that there was no documented evidence of any supportive visits after Resident A1 was verbally abused and threatened by Employee 3 on June 8, 2024. The Director of Social Services confirmed that there was no evidence that Resident A1 was assessed for psychosocial harm following the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48277 Based on observation and staff interview, it was determined that the facility failed to ensure that essential resident care equipment, a sit-to-stand lift, was in safe operating condition. Findings Include: Observation of the second floor B wing residents lounge area on July 2, 2024, at 10:35 AM, in the presence of the Director of Nursing (DON) revealed one out of the three facility sit-to-stand lifts was not operating properly. Observation revealed that the adjustable leg base of the sit-to-stand lift is designed to extend open to accommodate positioning around a toilet, recliner chair, wheelchairs and obstacles, and to provide a wider base of support when transferring a resident from one location to another. Observation revealed that the left leg of the base would not move when activated by the electronic controller. Interview with the DON on July 2, 2024, during the time of the observation, revealed that the facility failed to maintain essential resident equipment in a safe operating condition. 28 Pa. Code 201.18 (e)(2.1) Management