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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 48277 Based on review of Resident Council Meeting minutes and maintenance work orders, observation, and resident and staff interviews, it was determined the facility failed to ensure all residents had access to a resident-only telephone for one of 20 residents sampled (Resident 1) and failed to provide privacy for residents when having telephone calls on three out of three clinical nursing units. Findings include: Interview with Resident 1 on January 29, 2025, at 11:40 AM revealed that the resident-only telephone, located in the B-Wing Resident Lounge, was non-operational. Resident 1 stated that for three months, the facility had informed him that the guy isn't available to fix it. He reported the issue during the January 22, 2025, Resident Council Meeting, but the facility had not addressed his concern. Observation of the B-Wing Resident Lounge on January 29, 2025, at 12:06 PM revealed a landline telephone on a countertop without a dial tone. Further observation showed the phone jack pulled out from the wall with exposed phone cable wires. Interview with Employee 2 (licensed practical nurse) on January 29, 2025, at 12:09 PM indicated that the telephone in the B-Wing Resident Lounge was available for resident use, but only when operational. Employee 2 further revealed that residents could use the landline telephone located behind each nursing station but would need to request assistance from staff. The phone was positioned on the nursing station counter, requiring the resident to sit in front of the nursing station during the call. Employee 2 verified that this arrangement did not provide residents with privacy for their conversations. Review of the January 22, 2025, Resident Council Meeting minutes revealed documentation of a concern regarding the non-functional phone in the B-Wing Resident Lounge. Review of maintenance work orders from December 1, 2024, through January 29, 2025, showed no evidence that a work order had been placed to repair the phone in the B-Wing Resident Lounge. Interview with the Nursing Home Administrator on January 29, 2025, at 2:45 PM confirmed the facility failed to provide telephone access to all residents and failed to provide privacy for resident telephone calls. (continued on next page)

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
	395249	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This failure resulted in residents not having access to a functional, resident-only telephone and not being provided with privacy for telephone communications, impacting their ability to communicate confidentially and independently. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observations, a review of clinical records, review of facility grievances, Resident Council Meeting minutes, and resident and staff interviews, it was determined the facility failed to provide sufficient staff, providing direct services to residents, who possess the necessary competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as evidenced the facility's inability to appropriately manage and supervise the wandering and aggressive behaviors of two residents (Residents 4 and 20) out of 20 sampled. Findings include: Review of clinical record of Resident 4 revealed that the resident was admitted to the facility on [DATE], with diagnoses to include dementia with other behavioral disturbances (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), and violent behavior. Resident 4 resided on the B-Wing. An End of PPS Part A Stay Minimum Data Set assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated January 18, 2025, indicated that Resident 4 was severely cognitively impaired with a BIMS (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information) score of 3 (0-7 represents severe cognitive impairment), and the resident was able to ambulate independently. Review of Resident 4's plan of care dated November 22, 2024, revealed a focus area related to elopement risk/wanderer due to disoriented to place and impaired safety awareness. Interventions included: distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, TV, and books; notify appropriate departments of resident risk for elopement; every 15-minute checks, redirect as needed if resident found in other rooms. Another focus area identified regarding physical aggressiveness due to dementia and poor impulse control with interventions to: administer medications as ordered; assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc.; provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated; encourage activity participation for socializing with staff and peers; when resident becomes agitated, intervene before agitation escalates. Guide resident away from source of distress. Engage calmly in conversation. If response if aggressive, staff to walk resident calmly away and approach later. Despite these interventions, nursing documentation from November 21, 2024, through January 29, 2025, showed frequent incidents of wandering into other residents' rooms, exit-seeking behaviors, and aggression toward staff and other residents as follows: November 21, 2024, at 9:42 PM - resident was wandering into other residents' rooms and pushing on exit doors. Redirected by staff multiple times. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 22, 2024, at 2:59 PM - resident put on 15-minute checks for wandering/safety. November 23, 2024, at 4:35 PM - resident wandering in hall and in and out of other resident's rooms. November 23, 2024, at 7:45 PM - awake, alert and verbal with confusion. Going in and out of other residents' rooms. Constant redirection needed. November 24, 2024, at 3:50 PM - resident wandering in and out of residents' rooms. November 24, 2024, at 10:18 PM - wandering into other residents' rooms. Consistent redirection needed. November 25, 2024, at 4:30 AM - resident with abnormal behavior, wandering and entering other residents' rooms. Redirected may times. November 25, 2024, at 2:45 PM - resident continues to continuously ambulate up and down hallways, and in and out of activities. November 29, 2024, at 9:55 PM - wandering in other residents' rooms. Constant redirection needed. December 2, 2024, at 2:28 PM - resident insists on ambulating with increased agitation noted on redirection. Exit seeking behaviors observed majority of shift. December 3, 2024, at 4:14 - wandering up and down halls, not easily redirected. Some aggression when showing resident his room. December 3, 2024, at 6:04 PM - resident with behaviors this shift seen yelling in dining room, trying to go behind the counter by the food trays. December 9, 2024, 11:36 PM - resident does go into other residents' rooms but is easily redirected. December 11, 2024, at 8:01 PM - wandering in other rooms. Constant redirection needed. December 12, 2024, a 7:46 AM - resident with behaviors at start of shift. Resident taking clothing from roommate's closet. Roommate upset with resident. Wandering in hall until 1:00 AM. December 14, 2024, at 20:42 AM - wandering in and out of room, redirected several times. December 20, 2024, at 3:01 PM - frequent redirection needed often. In/out of other residents' rooms. December 21, 2024, at 4:30 AM - resident sitting in bed in room B2D (resident's room is B1D). Upon standing from bed, resident had pillow under his foot and started to slide and was lowered to floor by nurse. 15 min checks maintained. December 21, 2024, at 2:34 PM - wandering in and out of rooms on B Wing. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 21, 2024, at 9:33 PM - wandering in other rooms. Redirected by staff multiple times. December 22, 2024, at 2:50 PM - wandering in and out of other resident rooms. December 22, 2024, at 6:58 PM - ambulating up and down hall, going into other rooms. Redirected multiple times. December 23, 2024, at 2:18 PM - ambulates in and out of other residents' rooms. December 24, 2024, at 8:58 PM - Res complained of pain left foot. Xray results: subacute fracture of 5th metatarsal (bone in the foot). New order to be non-weight bearing (NWB) to left foot. Ortho consult. December 30, 2024, at 11:03 PM - ambulating up and down hall, constant redirection needed to use wheelchair due to NWB status to left leg. January 16, 2025, at 10:55 AM - reviewed with CRNP (certified registered nurse practitioner) recommendations from ortho appointment. New order received to discharge NWB statue to left lower extremity. January 17, 2025, at 2:56 PM - wandering in and out of other residents' rooms. January 21, 2025, at 7:48 AM - wandering into next room at times. January 24, 2025, at 2:36 PM - ambulating up and down the hall, going into other residents' rooms. January 25, 2025, at 10:18 PM - wandering into other resident rooms. On December 24, 2024, Resident 4 sustained a subacute fracture (break of a bone in the healing stage which causes pain) of the left foot, raising concerns regarding the adequacy of supervision Review of clinical record of Resident 20 revealed that the resident was admitted to the facility on [DATE], with diagnoses to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). The resident resides on the B- Wing. An Admission Minimum Data Set assessment dated [DATE], indicated Resident 20 was severely cognitively impaired with a BIMS score of 3, and the resident was able to ambulate with supervision or touching assistance. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 20's plan of care dated November 29, 2024, revealed a focus area of elopement risk due to disoriented to place, impaired safety awareness, noncompliant with assist to transfer and ambulate with interventions to include: social service visit as needed; wander guard system (system to alert staff of location); and when redirecting resident, approach in calm manner. Another focus area identified regarding physical aggressiveness due to dementia and swinging cane at staff with interventions to include: assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc.; monitor/document/report as needed, any signs/symptoms of resident posing danger to self and others; offer wheelchair when behaviors escalate; and when resident becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. Nursing documentation from November 29, 2024, through January 29, 2025, revealed frequent incidents of wandering into other residents' rooms, threats toward staff, verbal aggression, and physical aggression, including attempting to strike multiple staff members. Behaviors as follows: December 6, 2024, at 5:52 PM - resident ambulates in hallways, can be nasty at times, cursing at staff. December 7, 2024, at 4:57 AM - wandering in hall at start of shift, easily redirected. Resident went to sleep at approximately 2:00 AM. Noted steady gait with walking with cane. December 9, 2024, at 2:21 PM - resident with confusion this shift with behaviors present. Ambulating with cane in hall. Confusion present, attempting to go into other residents' rooms. Upon staff redirection, resident had times of increased agitation. At one point, attempting to hit multiple staff with cane. Resident also calling staff inappropriate names. December 10, 2024, at 3:34 AM - wandering earlier in shift. Resident went in room B15. When asked to move back to his own room, the resident began yelling at the other resident. December 11, 2024, at 2:41 PM - resident periodically agitated. Pulling away and swinging fist when staff offers assistance. Continues to urinate in garbage cans and personal green tote. December 11, 2024, at 10:29 PM - wandering in other residents' rooms, redirected with success. December 12, 2024, at 7:06 AM - resident wandering at start of shift in and out of other resident rooms, difficult to redirect. Went to bed at approximately 2:00 AM. December 13, 2024, at 11:27 AM - resident cursed, threw a wet rag, and told the nurse to get the f*** away from him! December 15, 2024, 7:01 AM - awake on and off this shift. Difficult to redirect at times. In and out of other resident rooms. December 15, 2024, at 2:14 PM - going in and out of other resident rooms, redirection often difficulty. December 17, 2024, at 3:36 PM - resident spit at nurse, telling nurse to leave him he f*** alone. Ambulating in and out of room. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 18, 2024, at 12:37 AM - resident with behaviors at the time. Sitting in wrong room. When asked to go back to own room, he refused and tried to hit the nurse with his cane. Resident eating and drinking other resident's snacks. Resident stating that the men in this room are his cousins and unable to redirect. Transferred back to room in chair, cursing at nurse. December 18, 2024, at 3:38 AM - continues to wander into other resident rooms and becomes agitated when asked to leave the room. December 18, 2024, at 10:33 PM - wandering into rooms. December 20, 2024, at 10:47 PM - wandering into other resident rooms. Difficult to redirect. December 21, 2024, at 4:48 AM - resident with behaviors all shift, in and out of other resident rooms, in other resident beds, eating other residents' snacks. Very difficult to redirect, swinging at staff when assisted to own room. December 30, 2024, at 4:41 AM - currently resting in empty bedroom B1W. Wandered there after using the connecting bathroom. Resident refusing to get out of this bed despite several attempts. December 31, 2024, at 8:40 PM - wandering up and down hall into rooms, constantly redirected by staff. January 7, 2025, at 9:11 PM - resident with behaviors this shift, going in and out of other resident rooms, coming behind nurse's station, threatens staff when attempting to redirect, distractions ineffective. January 8, 2025, at 9:46 PM - ambulating up and down hall with cane, wandering into other rooms. Constant redirection needed. January 11, 2025, at 10:15 PM - resident wanders throughout unit. On occasion, has threatened others with his cane. Resident also yells at others January 12, 2025, at 11:20 AM - resident with increased aggressive behaviors with staff. Swung cane and used vulgar language at nurse aide. January 15, 2025, at 2:04 PM - in and out of other resident rooms. January 16, 2025, at 6:51 AM - in and out of resident rooms. Redirection given multiple times. Aide sat one-on-one with resident for part of shift to monitor. January 21, 2025, at 7:44 AM - wandering all shift in other resident rooms. January 27, 2025, at 10:40 PM - he did act up when fell ow nurse tried to get him out of nurse's station. January 28, 2024, at 4:18 AM - ambulating through all from start of shift until approximately 1:30 AM. In and out of resident rooms. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Despite documented aggressive behaviors, the facility failed to ensure that adequate staff were present to effectively supervise and manage these behaviors. Interviews conducted on January 29, 2025, between 11:39 AM and 1:00 PM with four cognitively intact residents residing on the B-Wing indicated following: Resident 1 reported he is afraid to leave this room because Resident 20 comes into my room to see what he can steal. He stated that the facility provided him with a Velcro stop sign to place at the entrance to his room but noted that staff do not consistently put the stop sign in place when they exit his room, leaving him vulnerable to unwanted wandering residents. Observation on January 29, 2025, at 11:38 AM, prior to entering Resident 1's room, revealed that the stop sign was not in place on the entryway, allowing easy access into Resident 1's room. Continued interview with Resident 1 revealed that is scared to death of Resident 4 and Resident 20. He stated a few days ago he was in the hallway and Resident 4 was coming down the hall and raised his fist and said, do you want to fight. Resident 1 moved to the other side of the hall and went back to his room. Then Resident 4 came into his room asking, Where is Margaret? He made a fist and came after me and then the nurse took him out. Resident 1 reported another incident occurred on January 25, 2025. He stated that Resident 20 came into his room and stole one of his shirts. He stated, he keeps coming back into my room even though the nurse and myself keep telling him it's not his room. The resident stated he filed two grievances for both occurrences, but the facility has not addressed his recent concerns. He also stated he voiced his concern regarding Resident 4 and 20 at previous Resident Council Meetings. Review of facility's grievance for December 2024, and January 2025, revealed no grievance filed on behalf of Resident 1 or any grievances filed regarding Residents 4 and 20. Review of the Resident Council Meeting minutes for December 2024, and January 2025, revealed no concerns documented regarding intrusive wandering residents in the meeting minutes. Interview with Resident 18, Resident Council President, revealed concerns reported by Resident 1 regarding Residents 4 and 20 were brought up in past meetings. He indicated the January 22, 2025, meeting was conducted by the Nursing Home Administrator (NHA) and the Director of Human Resources. He stated that the NHA said she would follow up with Resident 1's concern. Continued interview with Resident 18 revealed that Residents 4 and Resident 20 wander into resident rooms frequently with Resident 20 making threatening remarks. Interview with Resident 19 reported that Residents 4 and Resident 20 have wandered into her room. She stated, everyone knows to stay away from them. She stated that they have entered her room, uninvited, multiple times, even at Two or three in the morning, keeping me up. She indicated a few weeks ago Resident 4 walked into her room, sat down on her chair and made a phone call. She said she is claustrophobic but sleeps with the door closed in order keep unwanted wanderers out and to keep her feeling safe. (continued on next page)

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	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook at Hampton	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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 17 stated Resident 20 was here last night. He sat down on my bed, and he wouldn't leave. My daughter was here and rang the buzzer. She continued, that's the second or third time he's been in my room, mostly in the evening. She stated when she calls for help, staff come in to remove him, but it makes her feel very uncomfortable and uneasy. Interview with two staff members on January 29, 2025, at approximately 11:30 AM, who wish to remain anonymous, indicated Resident 4 and Resident 20 are difficult to manage and keep track of due to their dementia, behaviors, and ability to ambulate independently. They feel the facility does not assign enough staff members to the B-Wing to manage behaviors and conduct the 15-minute checks required of multiple residents who reside on the B-Wing. One staff member revealed staff are afraid of Resident 20 due to his violent outburst and physical aggressiveness. Interview with Employee 1 (activity aide) on January 29, 2025, at approximately 12:20 PM confirmed that Residents 4 and Resident 20 do not engage in group activities as they either refuse to attend or will get up and leave the group activity. The Nursing Home Administrator (NHA) and Director of Nursing (DON) admitted they were unaware of the extent of these behavioral incidents and could not provide evidence that sufficient staff with appropriate skills were assigned to the B-Wing. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 29, 2025, at approximately 2:45 PM reported they were unaware of the extent to Residents 4 and 20's intrusive wandering and the negative effects it was having on the residents on the B-Wing. They were unaware of the grievances filed by Resident 1 and denied knowledge of his voiced concern regarding the intrusive wanderers during the January 2025 Resident Council Meeting. They could not provide evidence that sufficient staff with appropriate skills were assigned to the B-Wing.could not provide evidence that sufficient staff with appropriate skills were assigned to the B-Wing. The facility failed to provide adequate staffing levels with the necessary competencies to ensure the supervision and safety of residents with dementia, leading to repeated incidents of resident-on-resident intrusions, aggressive behaviors, and safety concerns, to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being. 28 Pa Code 211.12 (d)(3)(4)(5) Nursing services 28 Pa. Code 201.18 (e)(1)(3) Management 28 Pa. Code 201.20 (a)(6) Staff development