

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  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook at Hampton		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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of clinical records, facility policies, internal investigative documentation, and resident and staff interviews, it was determined the facility failed to ensure that two residents (Residents 27 and 31) out of a sample of 21 residents were free from abuse from a resident with a known history of physical aggression (Resident 82).</p> <p>Findings including:</p> <p>A review of the current facility policy entitled Policy and Procedure Vulnerable Adult Abuse and Prevention, last reviewed by the facility March 1, 2025, revealed it was the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment, or exploitation and to enhance the life of all residents through strong programming and appropriate care and treatment. There is a zero tolerance for abuse or harm of any type. Residents and staff will be monitored for protection.</p> <p>The facility's policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, hitting, slapping, kicking, punching, biting, or corporal punishment of a vulnerable adult. Additionally, residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the residents, family members or legal guardians, friends, or other individuals.</p> <p>As part of the facility's resident protection program the facility was to assess the facility's population for behaviors that could result in maltreatment of residents. It included that the facility would assess, care plan, and monitor resident's needs and behaviors such as entering other resident's rooms, wandering behaviors, verbal outbursts, residents with communication disorders, those who are nonverbal and those that require heavy care and/or totally dependent on staff.</p> <p>A review of Resident 82's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) with behavioral disturbance (behavioral and psychological symptoms such as agitation, anxiety, and psychosis), and anxiety (is a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome).</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395249
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 82's comprehensive person-centered plan of care, initiated on April 23, 2025, indicated the resident used antipsychotic, antianxiety, and antidepressant medications for Alzheimer's disease (decline in brain function which causes memory loss and causes brain tissue to breakdown) with behaviors such as aggression and history of intrusive wandering. Planned interventions included encourage activities for socialization and diversion, administer antipsychotic medication as ordered by physician and monitor for side effects and effectiveness, consult with pharmacy, MD to consider dosage reduction when clinically appropriate and consult psychiatric services.</p> <p>Review of Resident 82's quarterly MDS (Minimum Data Set a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status a tool to assess the residents attention, orientation and ability to register and recall new information) of 3, which indicated the resident had severe cognitive impairment, a score of 00-07 indicates severe cognitive impairment.</p> <p>A review of facility-provided investigative documentation completed by Employee 3, agency registered nurse (RN), dated May 23, 2025, at 5:45 PM, revealed that Resident 82 was observed placing his arms around the neck of Resident 27, who was seated in a wheelchair in the television lounge. Staff intervened, and neuro checks for both residents were within normal limits. Resident 82 was placed on one-to-one supervision for safety, and the physician, responsible party, and local authorities were notified. Psychiatric consultation was ordered.</p> <p>A witness statement by Employee 4, an activity aide, dated May 23, 2025, described overhearing Resident 27 ask Resident 82 to stop pushing him. Upon returning to the area, Employee 4 observed Resident 82 with both arms around Resident 27's neck. Staff separated the residents.</p> <p>A witness statement completed by Employee 4, an activity aide, dated May 23, 2025, revealed that around 5:30 PM I was walking a resident to the dining hall, and I overheard Resident 27 asking Resident 82 to stop pushing him with his wheelchair and when I came out of the dining room I witnessed Resident 82 choking (arms around neck) Resident 27 and then I intervened and called for help. Employee 4 observed Resident 82 with both arms around Resident 27's neck. Staff separated the residents.</p> <p>A review of a witness statement provided by Resident 27 dated May 23, 2025, noted, I was in the TV room watching TV when Resident 82 came in from the hallway. He began slamming the back of my wheelchair. I asked him what he was doing and to stop! Resident 82 stood up and came behind me and put his arms around my neck. I got really mad and reached my right arm above my head and hit Resident 82. Then, staff entered and removed Resident 82 from the room.</p> <p>Further review of the investigation revealed that Resident 82, the alleged perpetrator, often became agitated following the departure of his significant other after visits. Documentation indicated that Resident 82's significant other had left the facility only minutes prior to the incident involving Resident 27. Facility staff were educated on assisting the resident with transition-related behaviors and offering diversionary activities upon her exit. The significant other informed the facility that she would notify the unit nurse prior to leaving the premises in the future. Facility staff also indicated that efforts would be made to keep Resident 82 separated from the residents involved in the physical altercations during activities, use of common areas, and in dining settings.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of physician's orders dated May 23, 2025, for 1:1 supervision every shift for behaviors until May 24, 2025, at 11:59 PM, for safety/behaviors after which every 30-minute safety checks were ordered.</p> <p>A review of the facility's consulted psychiatric services PMHNP (Psychiatric Mental Health Nurse Practitioner) dated June 6, 2025, at 3:25 PM, revealed that Resident 82 was seen for follow up visit and staff reported the resident had episodes of verbal and physical aggression and was not always able to be easily redirect. Recommendations included to monitor and document any changes in mood such as increased signs and symptoms of depression or anxiety, mood lability, or generalized psychiatric decline, encourage social interactions/participation in group activities in facility to prevent feelings of isolation, provide supportive care as needed, non-pharmacological interventions and safety interventions, and routine follow up in 2 weeks or earlier if needed.</p> <p>A clinical record review from May 24, through June 6, 2025, revealed that nursing staff documented that Resident 82 had episodes of yelling and cursing at staff and other residents with unsuccessful redirection with activities and emotional support, and frequently self-propelled in his wheelchair throughout the unit and observed walking unassisted.</p> <p>Additionally, a review of a nurse progress note dated June 6, 2025, at 2:44 PM, documented Resident 82 was combative and aggressive this tour. Offered nap, tv, music, activities food and fluids. Frequently looking for significant other.</p> <p>A review of facility-provided investigative documentation completed by Employee 5, a registered nurse (RN), dated June 7, 2025, at 6:45 PM, revealed a second incident occurred involving Resident 82 and Resident 31 (BIMS of 15, indicating intact cognition). Facility documentation completed by Employee 5, a registered nurse, revealed that Resident 31 exited his room and reported that Resident 82 had grabbed him by the neck and pushed him. Redness was noted on Resident 31's neck. The residents were separated, and Resident 82 was moved to another room.</p> <p>A witness statement completed by Employee 6, a licensed practical nurse (LPN), dated June 7, 2025, indicated that when the incident occurred between Resident 82 and Resident 31, I was in the dining room. The last time I saw both residents was at approximately 6:15 PM, and they were both in their room. Resident 82 was sitting in his chair and Resident 31 was sitting on his bed. After dining room began, I began passing medication when Resident 31 came to me and told me that his roommate (Resident 82) put his hands around his neck and then his arms and seemed very upset. I immediately brought Resident 31 to the supervisor to discuss what the resident just explained.</p> <p>Resident 31's witness statement dated June 7, 2025, no time noted, indicated, My roommate and I were both standing in our room and out of nowhere he pushed me against the wall and told me not to bother the girls. I told him I won't, and he grabbed my neck, and I pushed him and ran out of the room, I started crying.</p> <p>Further review of the facility-provided investigative documentation completed by Employee 5, revealed that Resident 82 was not able to describe what happened. Residents were separated and Resident 82 room was changed. Additional interventions included 1:1 supervision for safety/behaviors and consult psychiatric services.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On June 12, 2025, at approximately 11:00 AM, an interview was conducted with Resident 31, a cognitively intact resident, regarding the incident that occurred with his previous roommate, Resident 82, on June 7, 2025, at 6:45 PM. Resident 31 stated, that guy is a brut, everything was fine and then he just snapped. I didn't provoke him, he just pushed me up against the wall and then put his hands around my neck, and then held my arms. I pushed him away and ran out to tell my nurse and they helped me. Additionally, Resident 31 reported that after the incident he was shaken up but felt safe because Resident 82 was moved to another location in the facility.</p> <p>Despite documented history of aggression, physical altercations, and psychiatric recommendations, the facility failed to maintain consistent and adequate supervision of Resident 82 to prevent repeated incidents of physical aggression. The second incident, which involved physical harm and emotional distress to Resident 31, occurred after a prior event involving similar aggression had already been identified. Additionally, the facility failed to substantiate abuse allegations made by Resident 31 despite evidence including witness statements and physical signs of injury.</p> <p>During an interview conducted on June 12, 2025, at approximately 10:35 AM, the facility's Nursing Home Administrator (NHA) stated the facility could not confirm that abuse had occurred because staff had not directly witnessed the incident involving Resident 31. The NHA reported the allegation could not be substantiated, despite facility investigative documentation noting visible red marks on Resident 31's neck and no documented history of the resident making false allegations in the clinical record or comprehensive care plan. The NHA also acknowledged that Resident 82 should have been provided with increased staff supervision due to his history of outbursts, aggressive behavior, and intrusive wandering, in order to prevent potential harm to other residents.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident Rights.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records and staff interview, it was determined the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of one resident out of 21 sampled (Resident 31).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 31 was admitted to the facility on [DATE], with diagnoses to include major depressive disorder (a mood disorder characterized by persistent low mood and anxiety (feelings of worry and unease).</p> <p>Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated April 14, 2025, indicated the resident had 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 equates to being cognitively intact).</p> <p>Further review of the clinical record revealed a progress note dated June 7, 2025, at 6:33 PM, indicating Resident 31 revealed his roommate grabbed his throat.</p> <p>A review of facility-provided investigative documentation completed by Employee 5, a registered nurse (RN), dated June 7, 2025, at 6:45 PM, revealed some redness noted on Resident 31's neck. No bruises or abrasions noted to skin. Resident 31 reported that Resident 82 caught him by surprise and pushed him and told him not to bother the girls. The incident occurred while both residents were in their shared room. Immediate interventions included separating the residents and initiating a room change.</p> <p>A progress note dated June 10th, 2025, at 5:25 PM showed the resident was still feeling upset about the incident with his roommate and expressed a need for support in managing his distress, including education from a psychiatric provider.</p> <p>An interview with Employee 1 (Social Services) on June 12, 2025, at approximately 11:30AM confirmed that no social services visit or intervention had been provided to Resident 31 in response to the altercation to address his psychosocial needs.</p> <p>An interview with the Nursing Home Administrator (NHA) on June 12, 2025, at approximately 12:00 PM confirmed there was no documented evidence that social services interventions were provided to support Resident 31's psychosocial well-being following the incident with his roommate.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p> <p>28 Pa. Code 211.16 (a) Social Services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, review of select facility policy and clinical records, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of two medication carts observed (C Hall).</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Labeling and Storage last reviewed by the facility March 1,2025, indicated that multi-use medication vials/bottles that have been opened or accessed (e.g. seal broken) are to be labeled with the date they were opened to ensure proper tracking for expiration purposes.</p> <p>An observation of the medication cart located on C Hall unit on June 11, 2025, at 8:22 AM, in the presence of Employee 2 (Licensed Practical Nurse ) of the medication stored in the medication cart, revealed one (1) multi-dose insulin pen of Insulin Lispro (a fast acting insulin medication used to lower blood sugar) and two (2) multi-dose pens of Insulin Glargine (a long acting insulin medication used to lower blood sugar) that had been opened and available for use, but not dated when initially opened.</p> <p>Further observation revealed one (1) multi-dose insulin pen of Insulin Glargine with a date on the cap of the pen indicating the pen was opened April 30, 2025.</p> <p>Review of manufacturer safety information revealed the multi-dose pen of Insulin Glargine is to be discarded 28 days after opening indicating the dated pen should have been discarded on May 27, 2025.</p> <p>An interview with Employee 2 (LPN) on June 11, 2025, at 8:24 AM, confirmed all three (3) multi dose insulin pens one (1) Insulin Lispro and two (2) Insulin Glargine were opened, available for use, currently being used for administration, and not dated when initially opened with one pen of insulin glargine being used past the expiration date.</p> <p>Interview with the Nursing Home Administrator (NHA) on June 11, 2025, at approximately 11:00 AM, confirmed the facility failed to adhere to acceptable storage and labeling practice for multi-dose medications.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services.</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services.</p>		