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	04/10/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with the resident, resident representative, and facility staff, it was determined the facility failed to honor the resident's preferences and failed to provide written notice, including the reason for the room change, prior to a facility-initiated room change for one of 22 residents reviewed (Resident 17).Findings include: Review of the facility policy titled Room Change last reviewed by the facility on January 16, 2026, indicated that the residents' preferences should be considered when making a room or roommate change. Whenever a resident is transferred from one room to another within the facility, a written notice of transfer must be provided to the resident and/or family prior to the move, according to state law. The resident should be provided with a tour of the new location, a chance to meet his/her new roommate and express any concern about the move. The notice is given in advance, except in situations outside the facility's control such as change in level of care, change in their medical or treatment program, or for their own or another residents' welfare as documented in the medical record. At the time of the survey ending April 10, 2026, all beds in the facility were licensed and dually certified for participation in both the Medicare and Medicaid programs. A review of Resident 17's clinical record revealed the resident was admitted to the facility on [DATE], and initially resided on B Hall. Documentation indicated the resident was transferred to a room on A Hall on January 23, 2026. During an interview on April 9, 2026, at 2:15 PM Resident 17, a cognitively intact resident with a BIMS score of 15 (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and the ability to register and recall new information, a score of 13-15 equates to intact cognition), stated that after returning from a five-day hospitalization on January 22, 2026, she awoke to staff packing her belongings. She reported she was not informed where she was going or who she was rooming with. She was not provided with the opportunity to tour the new room or meet the new roommate. She stated staff informed her only that her current room was being renovated and the move was temporary. The resident reported she was extremely upset and distraught, not only about the room change but that she was given no advance notification to prepare for the move. She acknowledged she was hospitalized for 5 days but stated that her daughter, who is her resident representative, was not notified of the room change during the resident's hospitalization. During a telephone interview on April 9, 2026, at 3:00 PM, the resident's daughter reported dissatisfaction with how the facility handled the room change. The daughter stated she received a telephone call from Social Services on the morning of January 23, 2026, informing her that her mother would be moving to A Hall that afternoon. The daughter stated she did not receive advance notice or written notification of the room change. She reported that Social Services informed her the resident would be assigned to a window bed, which conflicted with the resident's expressed preference for a bed closer to the door and bathroom. The daughter stated the resident was upset and had not been provided the opportunity to see the new room or meet the roommate prior to the move. Review of the clinical record revealed no documentation that written notice, including the reason for the room change, was provided to the resident or the resident representative prior to the relocation. There was no documented evidence that the resident's preferences were considered or that the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was offered the opportunity to view the new room or meet the roommate prior to the move. During an interview on April 9, 2026, at 2:00 PM, Social Services provided a document titled Room Change Request Letter for Resident 17. Review of the document indicated verbal notification was provided on January 23, 2026. The facility was unable to provide evidence that written notification, including the reason for the move, was provided to the resident and/or representative prior to the room change. 28 Pa Code 201.29 (a) Resident Rights.28 Pa Code 211.10 (c)(d) Resident Care Policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and staff interview, it was determined the facility failed to establish mechanisms for documenting and communicating a resident's refusal of ordered laboratory monitoring to the interdisciplinary team (group of professionals from two or more disciplines who collaborate to plan and evaluate care) and failed to ensure staff followed facility policy regarding refusal of treatment for one of 22 residents reviewed (Resident 12).Findings include: Resident 12 was admitted to the facility on [DATE], with diagnoses including epilepsy, nonintractable, without status epilepticus (a chronic neurological disorder characterized by recurrent seizures caused by abnormal electrical activity in the brain). A review of Resident 12's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 5, 2026 revealed that Resident 12 was moderately cognitively impaired with a BIMS score of 7 (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 7 indicates substantial challenges in cognitive abilities). A review of the facility policy titled, Resident Rights: Refuse and/ or Discontinue Care or Treatment, last reviewed January 16, 2026, indicated residents have the right to refuse care or treatment prescribed by the healthcare provider. The policy defined treatment as services provided for purposes of maintaining / restoring health, improving functional level, or relieving symptoms. The procedure indicated if a resident refuses care or treatment, the Director of Nursing or designee will meet with the resident to determine the reason for refusal, attempt to resolve concerns, discuss alternative options and potential consequences of refusing treatment, and document detailed information related to the refusal in the medical record. A review of Resident 12's physician orders revealed an order dated February 26, 2025, for laboratory monitoring of Keppra (levetiracetam, an anticonvulsant medication used to prevent seizures), Vimpat (lacosamide, an anticonvulsant medication used to control seizure activity), and Vitamin D level (a nutrient that supports bone and neurological health). The physician ordered these laboratory tests every 90 days to evaluate whether medication levels remained within a therapeutic range (the level at which a medication is effective without causing harmful side effects) and to support clinical decision-making related to seizure prevention and medication management. Monitoring Vitamin D levels is clinically relevant because low Vitamin D levels have been associated with increased seizure frequency in some individuals, and anticonvulsant medications may contribute to reduced Vitamin D levels. Keppra and Vimpat are commonly prescribed together to improve seizure control in individuals with epilepsy. A clinical record review of the document titled Laboratory Services Requisition dated September 9, 2025, indicated Resident 12 refused to allow the laboratory staff to obtain blood work and evaluate the laboratory values, Keppra, Vimpat, and Vitamin D. The specific laboratory values, Keppra, Vimpat, and Vitamin D, are important for clinical decision-making as it pertains to Resident 12's primary diagnosis reflective of the potential for seizure activity. The clinical record lacked documentation that the interdisciplinary team assessed the reason for the refusal, discussed alternative options such as rescheduling the laboratory draw, evaluated the potential clinical impact of refusal, or communicated the refusal to the practitioner for further medical decision-making. The medical record did not include evidence that staff implemented the facility policy requiring follow-up evaluation, documentation, and communication regarding refusal of treatment. There was no evidence in the medical record, including narrative progress notes or physician orders, that a member of the interdisciplinary team met with Resident 12 to determine why Resident 12 refused to allow blood work to be obtained on September 9, 2025. The medical record did not include evidence the facility attempted to address the reason for refusal, discuss alternative options (e.g. attempt at another time), and the potential outcomes related (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the refusal. The absence of specific laboratory values places one at risk for inadequate medication management pertaining to seizure control since the laboratory values support clinical decision making, including seizure prevention and control. The medical record lacked detailed information related to the refusal of treatment (laboratory services) as stated in the facility policy. During an interview on April 10, 2026, at 11:00 AM, the Director of Nursing acknowledged the medical record did not contain documentation demonstrating the interdisciplinary team evaluated Resident 12's refusal of laboratory testing or followed the facility's policy regarding refusal of treatment. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 201.29 (a)(b) Resident rights.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies, and staff interview, it was determined the facility failed to ensure nursing services were provided in accordance with professional standards of quality, in accordance with Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to ensure that only qualified staff performed and documented the administration of intravenous therapy via a central venous catheter and failed to ensure accurate and consistent documentation of medication administration for one of 22 residents reviewed (Resident 86).Findings include: According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following: The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice. Chapter 21.145b. IV therapy curriculum requirements: (f) An LPN may perform only the IV therapy functions for which the LPNpossesses the knowledge, skill and ability to perform in a safe manner, except aslimited under S 21.145a (relating to prohibited acts), and only under supervisionas required under paragraph (1).(1) An LPN may initiate and maintain IV therapy only under the directionand supervision of a licensed professional nurse or health care provider authorizedto issue orders for medical therapeutic or corrective measures (such as aCRNP, physician, physician assistant, podiatrist or dentist).(g) An LPN who has met the education and training requirements of S 21.145b (relating to IV therapy curriculum requirements) may perform the following IV therapy functions, except as limited under S 21.145a and only under supervision as required under subsection (f): (1) Adjustment of the flow rate on IV infusions. (2) Observation and reporting of subjective and objective signs of adverse reactions to any IV administration and initiation of appropriate interventions. (3) Administration of IV fluids and medications. (4) Observation of the IV insertion site and performance of insertion site care. (5) Performance of maintenance. Maintenance includes dressing changes, IV tubing changes, and saline or heparin flushes. (6) Discontinuance of a medication or fluid infusion, including infusion devices. (7) Conversion of a continuous infusion to an intermittent infusion. (8) Insertion or removal of a peripheral short catheter. (9) Maintenance, monitoring and discontinuance of blood, blood components and plasma volume expanders. (10) Administration of solutions to maintain patency of an IV access device via direct push or bolus route. (11) Maintenance and discontinuance of IV medications and fluids given via a patient-controlled administration system. (12) Administration, maintenance and discontinuance of parenteral nutrition and fat emulsion solutions. (13) Collection of blood specimens from an IV access device. Review of the facility policy titled Administering Medications last reviewed by the facility on January 16, 2026, indicated that only staff licensed or permitted by the State may prepare, administer, or record the administration of medications. The policy further required that the individual administering the medication must sign the resident's Medication Administration Record (MAR) for the specific time and day the medication was administered. Review of the facility policy titled Parenteral Nutrition General Policies last reviewed by the facility on January 16, 2026, indicated that only a nurse with documented education and training in infusion therapy, including parenteral nutrition administration, and central venous access device management as designated by the facility and as allowed by state regulations, may administer parenteral nutrition. Parenteral nutrition is a method of delivering essential nutrients, including carbohydrates, proteins, fats, electrolytes, vitamins, and minerals, directly into the bloodstream intravenously, completely bypassing the digestive tract. It is (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used when a person cannot consume, digest, or absorb adequate nutrients through food or feeding tubes. Clinical record review revealed that Resident 86 was admitted to the facility on [DATE], with diagnosis to include severe protein-calorie malnutrition (a life-threatening, extreme nutritional deficiency characterized by significant weight loss) and surgical aftercare following surgery on the digestive system, and was admitted to the facility with a Total Parenteral Nutrition (TPN) central intravenous catheter (a specialized long-term intravenous line used to deliver concentrated nutrients directly into a large vein near the heart, because the digestive system cannot be used). Review of a physician's order dated April 5, 2026, directed staff to flush the central line with 10 cc (cubic centimeters, a metric used to measure liquid volume or the capacity of a substance, with 1 cc being equal to 1 milliliter) of normal saline before and after TPN administration twice daily (sterile salt solution used to maintain patency/keep the line open and functioning). Review of Resident 86's April 2026 Medication Administration Record (MAR) revealed that between April 5 through April 9, 2026, Employee 2 (Licensed Practical Nurse, LPN), Employee 3 (LPN), Employee 4 (LPN), and Employee 5 (LPN) signed the MAR as administering the central line flush before and after the administration of the TPN to Resident 86 through the TPN central catheter. However, review of nursing progress notes for April 6 through April 9, 2026, indicated that the Registered Nurse (RN) completed the central line flushes. Review of a physician's order dated April 6, 2026, instructed staff to administer TPN Electrolytes Intravenous Concentrate, 100 milliliters/hour intravenously one time a day for parenteral nutrition. Review of Resident 86's April 2026 MAR revealed that between April 6 through April 9, 2026, Employee 3 and Employee 4 documented on the MAR that they administered the TPN IV electrolyte infusion via the central venous catheter. However, corresponding nursing progress notes for April 6 through April 9, 2026, indicated that the RN performed the TPN administration. During an interview on April 9, 2026, at 1:00 PM, Employee 3 (LPN) stated she did not administer the TPN infusion or central line flushes because these procedures were outside her training and scope of practice. Employee 3 stated she notified the RN to perform these procedures. Employee 3 further stated that despite not performing the procedures, she documented on the MAR that she had administered the treatments, while separately documenting in the clinical record that the RN completed the procedures. During an interview on April 9, 2026, at 2:15 PM, the Director of Nursing confirmed that, according to facility policy, only RNs are permitted to administer TPN and perform central line flushes via a TPN central venous catheter. The Director of Nursing further confirmed that facility policy requires the nurse who administers the medication or treatment to accurately document the administration on the MAR. The facility failed to ensure that only qualified staff performed specialized intravenous therapy via a central venous catheter and failed to ensure accurate and consistent documentation of medication administration. 28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d) Nursing Services. 28 Pa Code 211.10 (c)(d) Resident Care Policies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication according to physician-ordered parameters for one of 22 residents reviewed. (Resident 9)Findings include: A review of the facility policy titled Administering Medications last reviewed on January 16, 20026, revealed the purpose of the policy was to ensure safe and effective administration of medication in accordance with physician orders and applicable state and federal regulations. The policy required medications to be administered in accordance with the provider's written or verbal orders after verification of the right medication, right dose, right route, right time, and confirmation of the resident's identity, and only when no contraindications (a clinical reason a medication should not be given because it may cause harm) were present. Resident 9 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, not intractable, without status epilepticus (a chronic brain disorder characterized by recurrent seizures from abnormal electrical activity in the brain) and Type 2 Diabetes Mellitus (a chronic metabolic disorder characterized by elevated blood sugar levels due to insulin resistance or inadequate insulin production). A review of Resident 9's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 27, 2026 revealed that Resident 9 was cognitively intact with a BIMS score of 14 (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 14 indicates cognitive function with minimal memory or thinking changes). A review of the physician's order dated September 1, 2025, directed staff to administer Insulin Aspart Injection Solution 5 units subcutaneously (method of administering medication into the fatty tissue layer just beneath the skin, allowing slow and sustained absorption into the body) two times a day. The physician order further directed staff to hold the insulin dose if Resident 9's blood glucose level was below 110 mg/dL (milligrams per deciliter, a measurement used to indicate the amount of glucose present in the blood). A review of the December 2025 Medication Administration Record (MAR), a clinical document used by nursing staff to record medication administration, revealed Aspart insulin 5 units was administered on the following dates and times despite blood glucose readings below the physician-ordered parameter of 110 mg/dL:December 12, 2025, at 4:00 PM - blood glucose reading of 97 mg/dLDecember 23, 2025, at 4:00 PM - blood glucose reading of 99 mg/dLDecember 26, 2025, at 4:00 PM - blood glucose reading of 106 mg/dL A review of the January 2026 Medication Administration Record (MAR) revealed Aspart insulin 5 units was administered on the following dates and times despite blood glucose readings below 110 mg/dL: January 13, 2026, at 12:00 PM - blood glucose reading of 104 mg/dLJanuary 15, 2026, at 12:00 PM - blood glucose reading of 81 mg/dL Administration of insulin when blood glucose levels were below the physician-ordered parameter prevented nursing staff from determining whether the medication was clinically appropriate to administer and increased the risk for hypoglycemia (abnormally low blood sugar levels that may cause dizziness, confusion, loss of consciousness, seizures, or other serious complications). The findings demonstrated that the medication was repeatedly administered without adherence to physician-ordered parameters and contrary to facility policy and accepted standards of nursing practice, which require nurses to follow medication orders accurately and ensure safe medication administration practices. The above findings were reviewed with the Director of Nursing on April 9, 2026, at 9:50 AM, who confirmed nursing staff failed to follow the physician order and administered insulin outside the ordered parameters on the dates identified above. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to ensure physician orders were followed for one resident (Resident 7) out of 22 residents reviewed. Findings include: A review of the facility policy, titled Pain Management and Assessment last reviewed on January 16, 2026, indicated the facility established a standardized method for assessing, monitoring, evaluating, managing and documenting pain in both cognitively intact and cognitively impaired residents. The policy directed staff to assess and document pain using a consistent and standardized pain assessment method appropriate to the resident's cognitive level. The policy required staff to assess and document pain including onset and duration, location, severity, alleviating, and aggravating factors, possible causes and accompanying sign and symptoms. Clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (a chronic medical condition in which the body does not properly use insulin, resulting in elevated blood glucose levels). A review of Resident 7's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 27, 2026 revealed that Resident 7 was 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 15 indicates no impairment in memory or thinking). Clinical record review indicated Resident 7 had a physician order dated July 16, 2025, for Oxycodone HCL (hydrochloride) oral tablet 5 milligrams (mg), (narcotic medication used to treat moderate to severe pain). The order directed staff to administer one tablet by mouth every six hours as needed (PRN) for severe pain rated 7 through 10. A numeric pain rating scale used to measure pain intensity, with 0 indicating no pain and 10 indicating the worst possible pain.Review of the September 2025 Medication Administration Record (MAR, a clinical document used to record medications administered to a resident) revealed staff administered Oxycodone HCL 5 mg outside the ordered parameters for severe pain (7-10) on the following dates: September 7, 2025, for a documented pain level of 0September 13, 2025, for a documented pain level of 0September 5, 2025, for a documented pain level of 5September 26, 2025, for a documented pain level of 6Administration of Oxycodone for pain levels of 0, 5, and 6 did not correspond with the physician's order specifying the medication was to be administered only for severe pain rated 7 through 10. Additional clinical record review indicated Resident 7 had a physician order dated July 23, 2025, for Tramadol HCL oral tablet 50 mg (narcotic-like medication used to treat pain). The order directed staff to administer 25 mg (one-half tablet) by mouth every six hours as needed for pain rated 4 through 6 on the numeric pain scale. Review of the October 2025 MAR revealed staff administered Tramadol 25 mg on October 9, 2025, for a documented pain level of 8. Administration of Tramadol for a pain level of 8 did not correspond with the physician's order specifying the medication was to be administered for moderate pain rated 4 through 6. During an interview conducted April 9, 2026, at 10:50 AM, the Director of Nursing reviewed the above findings related to administration of pain medications outside physician-ordered parameters on five occasions. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, observations, and staff interviews, it was determined the facility failed to ensure the ready availability of necessary emergency dialysis supplies for one of three residents reviewed who received hemodialysis (Resident 11).Findings include:According to clinical standards referenced by the National Kidney Foundation and Centers for Disease Control and Prevention (CDC), residents receiving hemodialysis (a life-sustaining treatment used when the kidneys are no longer able to adequately remove waste and excess fluid from the blood) are at risk for serious complications, including hemorrhage (severe bleeding) and bloodstream infection. Hemodialysis requires access to the bloodstream through either a central venous catheter (a tube inserted into a large vein to allow blood to circulate through the dialysis machine) or an arteriovenous fistula (a surgically created connection between an artery and a vein, typically located in the arm, that provides reliable vascular access for dialysis treatments). If a dialysis access device becomes dislodged, disconnected, or begins to bleed, immediate firm pressure must be applied and emergency medical assistance obtained to prevent rapid and potentially fatal blood loss. Clinical standards of practice indicate that emergency supplies, such as clamps (devices used to stop blood flow through dialysis tubing or catheters) and pressure dressings (bandages designed to apply sustained pressure to control bleeding), must be readily available to allow prompt intervention. A review of the policy Care of Hemodialysis Resident last reviewed January 16, 2026, indicated the facility will ensure the needs of the resident receiving hemodialysis are met by both the facility and the dialysis center. The policy indicated residents who require dialysis will receive care consistent with professional standards of practice, the comprehensive person-centered plan of care, and the resident's goals and preferences. The policy included post-dialysis care procedures and directed staff to monitor the dialysis access site for complications. The policy instructed staff to apply pressure for five to ten minutes to control bleeding from a fistula site (the surgically created access between the artery and vein used for dialysis) and to repeat pressure as needed until bleeding stops. Resident 11 was admitted to the facility on [DATE], with diagnosis which included end stage renal disease (the final stage of chronic kidney disease, where the kidneys no longer function adequately to sustain life). A review of Resident 11's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 25, 2026, revealed that Resident 11 was 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 15 indicating intact cognition).Clinical record review revealed a comprehensive care plan initiated March 20, 2026, which addressed Resident 11's need for ongoing hemodialysis treatments. The care plan directed staff to monitor the fistula site located in the left upper extremity (upper arm) for bleeding and instructed staff to apply pressure and obtain assistance in the event of bleeding or other complications. The care plan further specified that an emergency dialysis supply kit was to be maintained at the bedside to allow immediate response to complications related to dialysis access. Observation conducted on April 7, 2026, at 11:20 AM revealed no emergency dialysis supply kit, clamps, pressure dressings, or other dialysis access emergency supplies present at the bedside, mounted on the wall, or otherwise readily accessible in Resident 11's room. During the observation, Employee 1, Licensed Practical Nurse (LPN), confirmed the absence of emergency dialysis supplies in the resident's room. Employee 1 stated that an emergency kit containing appropriate dialysis emergency supplies should have been present and readily accessible according to the care plan. On April 7, 2026, at 2:15 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) regarding the absence of required emergency supplies for residents receiving hemodialysis. 28Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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	04/10/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 22 residents reviewed (Resident 3).Findings include: A review of Resident 22's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). A review of Resident 3's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 20, 2026, revealed Resident 3 was cognitively intact with a BIMS score of 14 (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 through 15 indicates cognition is intact). The MDS further revealed that the resident was assessed as yes to having a PTSD diagnosis. The resident's current care plan, in effect at the time of review on April 9, 2026, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Nursing Home Administrator on April 9, at 12:30 PM confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure the timely acquisition and availability of prescribed medications for one of five residents reviewed for unnecessary medications (Resident 29).Findings include: Review of the facility policy titled Ordering and Receiving Non-Controlled Medications last reviewed by the facility on January 16, 2026, indicated that medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate records of medication order and receipt. A clinical record review revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and anxiety. Review of a physician's order dated November 20, 2025, revealed an order for Levothyroxine Sodium (medication use to treat hypothyroidism, underactive thyroid) 125 mcg by mouth in the morning for thyroid disease. Review of the resident's Medication Administration Record (MAR) for April 1, 2026, through April 10, 2026, revealed the resident did not receive the prescribed Levothyroxine Sodium which was ordered to be administered at 6:00 AM, on April 8, April 9, or April 10, 2026. During an interview on April 10, 2026, at 12:15 PM the Director of Nursing (DON) confirmed the facility failed to ensure Levothyroxine Sodium 125 mcg was received from pharmacy prior to the depletion of the supply of the medication for Resident 29. There was no documented evidence the facility ensured the medication was obtained and available for administration as ordered. 28 PA. Code 211.10 (c)(d) Resident care policies. 28 PA. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, select facility policy, and interviews with resident, family and staff, it was determined the facility failed to establish and maintain an effective infection prevention and control program by failing to implement Transmission-Based Precautions in accordance with facility policy to reduce the potential spread of infection for one resident of 22 residents reviewed (Resident 86).Findings include:Review of the facility policy titled Isolation Precautions last reviewed by the facility on January 16, 2026, indicated that Transmission- Based Precautions (TBP) will be initiated when a resident is suspected or confirmed to have a communicable disease/infection that can be transmitted to another. Transmission-Based Precautions are additional infection control practices used along with Standard Precautions (routine infection prevention practices applied to all residents, such as hand hygiene and use of protective equipment when exposure to body fluids is anticipated) to prevent the spread of highly transmissible or epidemiologically significant organisms. Transmission-Based Precautions may include Contact Precautions used for infections spread through direct contact with the residents or indirect contact with contaminated surfaces or equipment. These precautions require use of gloves and gown when entering the room to prevent the spread of organisms by touch., Droplet Precautions - used for infections spread through respiratory droplets produced when a person coughs, sneezes, or talks. These precautions generally require the use of a mask., Airborne Precautions used for infections spread through very small particles that remain suspended in the air for long periods. These precautions typically require specialized respiratory protection, or Enhanced Barrier Precautions (EBP) infection control measures requiring gown and gloves during high-contact resident care activities when multidrug-resistant organisms are present, even if the resident does not have symptoms of infection.The procedure for implementing TBP include:1. TBP will be used when transmission cannot be reasonably prevented by standard precautions alone.2. Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (personal protective equipment e.g. gown and gloves).3. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves.4. Make PPE, including gowns and gloves available immediately outside of the resident room.5. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.6. Ensure hand sanitizer is easily accessible by the resident's room. In addition, the policy indicated that contact precautions will be implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment. Residents should be placed in a private room when available. Prior to entering the isolation room, the following steps are required:a. perform hand hygiene and apply gloves and gown prior to entering room.b. while providing direct resident care, wear gloves and wash hands after coming in contact with infectious material.c. remove gloves and perform hand hygiene before leaving room.d. adequately clean and disinfected items with an approved solution prior to removing the item from the room and before use on another resident A review of clinical records revealed Resident 86 was admitted to the facility on [DATE], with diagnoses to include infective endocarditis (a rare but life-threatening infection of the hearts inner lining or valves, typically caused by bacteria entering the bloodstream and attaching to the damaged heart tissues), vancomycin-resistant enterococci (VRE) bacteremia (a serious infection caused by enterococcus bacteria resistant to the antibiotic vancomycin), and bacterial peritonitis (a serious infection of the abdominal fluid). Review of the resident's plan of care dated April 6, 2026, indicated the resident required intravenous therapy, including Total Parenteral Nutrition (TPN, a method of delivering essential nutrients, including carbohydrates, proteins, fats, electrolytes, vitamins, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minerals, directly into the bloodstream intravenously, completely bypassing the digestive tract. It is used when a person cannot consume, digest, or absorb adequate nutrients through food or feeding tubes. TPN is administered via a central intravenous catheter, a specialized long-term intravenous line used to deliver concentrated nutrients directly into a large vein near the heart, because the digestive system cannot be used), and intravenous antibiotics for infection, including VRE in the blood. The care plan identified the need for Contact/Isolation Precautions due to the presence of VRE in the bloodstream. Observation on April 7, 2026, at 12:40 PM revealed no precaution signage posted at the entrance to Resident 86's room to inform staff and visitors of required Contact Precautions or necessary PPE prior to entry. Additionally, no appropriate waste receptacle or linen hamper was observed inside the room near the exit to allow proper disposal of PPE prior to leaving the room. Interview with Resident 86 and the resident's husband at the time of observation revealed they had not been informed of the need for Contact Precautions or the associated infection prevention practices. The resident and representative reported that staff had not consistently worn gowns when entering the room since admission. Observations on April 8, 2026, at 11:18 AM and 2:30 PM revealed multiple staff entered and exited the resident's room without wearing required PPE, including gowns and gloves, during resident care activities. During an interview on April 10, 2026, at 9:00 AM, the Director of Nursing and Infection Preventionist confirmed that the facility failed to implement its Infection Control policy related to Transmission-Based Precautions for Resident 86. Specifically, they acknowledged that appropriate precaution signage was not posted, required equipment such as linen and waste receptacles, were not in place, the resident and family were not educated regarding precautions, and staff did not consistently adhere to PPE requirements. 28 Pa Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.