

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Scenery Hills Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 680 Lions Health Camp Rd Indiana, PA 15701	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations and staff interviews, it was determined that the facility failed to ensure residents' environment remained free of accident hazards, by failing to ensure that safe water temperatures were maintained at the appropriate temperatures for resident safety in three of three resident areas (resident rooms on the North and South Halls and resident rooms in the corridor area), which placed residents in immediate jeopardy of the likelihood of serious bodily injury, harm or death. Findings include: The facility's policy regarding safety of water temperatures, dated February 6, 2026, indicated that tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 110 degrees Fahrenheit, or the maximum allowable temperature per state regulation. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. Interview with Resident 1 on April 29, 2026, at 2:01 p.m. revealed that she does not prefer to shower and used two basins to wash at the bedside. She indicated that the water is scalding hot and stated, Why would they give me scalding hot water. The resident resided in room [ROOM NUMBER] on the South Hall. This writer ran the water in the resident's bathroom sink at 2:24 p.m. and the water was hot enough to cause this writer to remove her hand after just seconds under the stream of water. The Maintenance Director obtained the water temperature in room [ROOM NUMBER] at 2:36 p.m. and the water temperature was reading 120 degrees Fahrenheit. An interview with the Maintenance Director at that time indicated that the water temperature should not be that high. On April 29, 2026, between 2:50 p.m. and 3:00 p.m., the water temperature in the resident bathrooms in the South Hall were as follows: room [ROOM NUMBER]/22 was 117.5 degrees Fahrenheit; room [ROOM NUMBER]/28 was 113.9 degrees Fahrenheit; room [ROOM NUMBER]/29 was 119.3 degrees Fahrenheit; room18 was 122.7 degrees Fahrenheit; and the water temperature in the sink in the shower room on the South Hall was 114.4 degrees Fahrenheit. Between 3:07 p.m. and 3:10 p.m., the water temperature in the resident bathrooms in the rooms in the corridor area were as follows: room [ROOM NUMBER] was 111.2 degrees Fahrenheit; room [ROOM NUMBER] was 111.2 degrees Fahrenheit; and room [ROOM NUMBER] was 123.6 degrees Fahrenheit. Between 3:11 p.m. to 3:30 p.m., the water temperature in the resident bathrooms in the North Hall were as follows: room [ROOM NUMBER]/9 was 110.1 degrees Fahrenheit; room [ROOM NUMBER] was 111 degrees Fahrenheit; room [ROOM NUMBER] was 111.9 degrees Fahrenheit; and room [ROOM NUMBER] was 112.2 degrees Fahrenheit. At 3:35 p.m., the water temperature in the residents' bathroom in room [ROOM NUMBER]/25 in the South Hall was 120.7 degrees Fahrenheit. Interview with the Maintenance Director on April 29, 2026, at 3:37 p.m. revealed that the water temperatures should not be that high. Interview with the Nursing Home Administrator on April 29, (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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2026, at 4:10 p.m. confirmed that the water temperatures noted to the above-listed areas should not be that high. On April 29, 2026, at 5:30 p.m. the Nursing Home Administrator was informed that the health and safety of the residents was placed in Immediate Jeopardy due to the water temperatures in resident care areas not being maintained at the appropriate temperatures for resident safety placing the residents at risk for scalding injuries. The Immediate Jeopardy template was provided to the Nursing Home Administrator. The facility submitted and implemented an immediate action plan that included turning off the hot water to the facility. [NAME] Brothers plumbing was dispatched immediately and were at the facility within 30 minutes of dispatch. Education, as per the facility policies, regarding water temperature safety and bed bath/shower/tub bath were started immediately and would continue until all staff were educated. When the plumbing issue is fixed, the Nursing Home Administrator/designee will audit water temperatures from all water spickets two times per shift for 24 hours, then every shift for three days, then 10 random spickets weekly for two weeks, then auditing per facility policy. The results of these audits will be reported to the monthly QAPI meeting for additional recommendations until substantial compliance is met. The Immediate Jeopardy was lifted on April 29, 2026, at 8:05 p.m. when it was confirmed that the plumbing company identified the problem, the hot water to the affected areas was diverted to the other tanks until the issue could be resolved, the water temperatures were at a safe level not to exceed 110 degrees Fahrenheit, present staff were educated, and that unscheduled staff would be educated before reporting for work. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of facility policies and employee job descriptions, as well as observations and staff interviews, it was determined that the facility's administration, Nursing Home Administrator and Director of Nursing, failed to effectively use its resources to promote resident safety and maintain the highest practicable physical well-being of residents in the facility by failing to ensure that safe water temperatures were maintained at the appropriate temperatures for resident safety in three of three resident areas (resident rooms on the North and South Halls and resident rooms in the corridor area), which placed residents in immediate jeopardy of the likelihood of serious bodily injury, harm or death. Findings included: The job description for the Nursing Home Administrator, undated, indicated that the administrator's essential job duties include overseeing staff, explaining the facility's policies and procedures to employees, as necessary and assisting departments in the use of policies and procedures, assuring that the facility is properly maintained, clean and safe for resident comfort and convenience, maintaining all equipment and supplies necessary to that end, assuring that adequate numbers of properly trained personnel are on duty at all times to meet the needs of the residents and comply with all regulations. The Nursing Home Administrator failed to ensure these responsibilities were carried out, as evidenced by water temperatures in resident care areas not being maintained at the appropriate temperatures for resident safety, placing the residents at risk for scalding injuries. This demonstrated a lack of effective oversight to address the safety of residents by failing to follow facility policies and comply with all regulations. The job description for the Director of Nursing, undated, indicated that the Director of Nursing was responsible for leading and managing the nursing department to ensure the highest standard of care for all residents. This role oversees clinical operations, supervises nursing staff, ensures compliance with regulatory requirements, and collaborates with other department heads to promote quality outcomes in a resident-centered environment. The Director of Nursing failed to ensure that nursing staff followed facility policies related to safe water temperatures placing the residents at risk for scalding injuries. Based on the findings, the facility's inability to ensure water temperatures in resident care areas were maintained at the appropriate temperatures for resident safety placed the residents at risk for scalding injuries and resulted in Immediate Jeopardy to the health and safety of residents on the North Hall, South Hall and residents in rooms in the corridor area. This demonstrated a systemic failure in the administration's oversight and resource allocation to ensure a safe environment for residents. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F689) 483.25(d)(1)(2) Accidents, revealed the facility's administration did not fulfill essential job duties to ensure resident safety and regulatory compliance. This included a failure to ensure that safe water temperatures were maintained at the appropriate temperatures for resident safety, placing the residents at risk for scalding injuries. Refer F689 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(3)(e)(1) Management 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		