STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395344	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Greenwood Hill	420 Pulaski Drive Pottsville, PA 17901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports and interviews with staff and residents it was determined the facility failed to ensure that one resident (Resident 1) was free from sexual abuse perpetrated by a facility staff member out of 6 residents sampled. This failure to prevent, identify, and respond appropriately to sexual abuse placed Resident 1 and all other residents in the facility at risk for further harm, resulting in Immediate Jeopardy. Findings include: A review of a facility policy entitled Abuse and Neglect Prevention revealed it is 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. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. Further it is indicated every resident has the right to be free from verbal, sexual, physical, and mental abuse. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD a group of lung diseases that cause ongoing breathing problems), type 2 diabetes (high blood sugar), and muscle wasting. A review of a Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 7, 2024, revealed the resident was cognitively intact with a BIMs score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). A review of a facility investigation report dated February 9, 2025, at 7:45 PM revealed Employee 1 NA (nurse aide) approached Employee 2 RN (registered nurse) in regard to an inappropriate encounter between Resident 1 and Employee 3 NA. The resident was assessed at the time and no injuries were identified. Further it was indicated Employee 3 was escorted from the building and the resident refused to be transferred and evaluated in the hospital. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a witness statement from Employee 1 NA dated February 9, 2025, revealed the employee was passing snacks out to the residents. The employee stated she knocked on Resident 1's closed door and observed the resident's bed was raised to Employee 3's waist height. The resident was lying on her left side. Employee 1, NA reported witnessing Employee 3 receiving oral sex from Resident 1. Employee 1 NA observed that Employee 3 NA was holding the resident's head and shoulders while engaging in thrusting motions. Employee 1 indicated Employee 3 was startled when he saw Employee 1 and moved away from the resident quickly. A review of a statement from Employee 3 NA provided to facility staff via telephone dated February 10, 2025, revealed the employee was done with his work and was doing a walk throughout the hallways. He indicated Resident 1's dinner tray was still in her room and went to get it. The employee stated the resident looked uncomfortable, so he turned her on to her side and put a pillow behind her back. Further he indicated Employee 1 NA was quiet and he did not hear her come into the room. The employee stated Employee 1 NA walked by and put a sherbet on the foot of the resident's bed. The employee then indicated he got the resident situated and fed her the sherbet. When he exited the room, he was told he had to leave the facility. A review of a statement dated February 10, 2025, revealed the resident was questioned about the incident that occurred. Resident 1 was asked what had occurred the night before and asked if she was in a relationship with Employee 3. The resident stated he was married but she did give him oral sex the night before. The resident indicated that it was not the first time she had seen his genitals. The resident stated in the past Employee 3 had touched her genitals and oral sex was preformed once before. An interview with Resident 1 on February 13, 2025, at 9:50 AM revealed the resident denied that any incident occurred with Employee 3. The resident stated Employee 3 NA did come in her room, but they were just talking. During the interview the resident appeared to be uncomfortable and evasive when asked why the Employee would have come into her room and closed the door and pulled the curtain shut just to talk with her. The resident stated he didn't force me to do anything, and she stated she was fine. A second interview was completed with Resident 1 on February 13, 2025, at 11:45 AM. The surveyors explained to the resident they read her witness statement she provided to the facility on [DATE], about an alleged sexual encounter that occurred and asked if she would like to talk about the incident. Resident 1 stated she was afraid she and Employee 3 was going to get in trouble. The surveyors explained to the resident she was not in trouble for anything. The resident then indicated Employee 3 had initiated sexual contact with her on February 9, 2025. The resident stated he approached her in her room was talking to her about sexual things. The resident stated one thing led to another and she performed oral sex on the employee. She indicated the oral sex stopped when Employee 3 pulled away from her when another staff member came into the room and saw what was happening. The resident stated this was not the first time she had a sexual encounter with Employee 3. The resident indicated that for at least a month her and Employee 3 would have sexual conversations, and she performed oral sex on Employee 3 one other time while he touched her bare genitals and penetrated her with his fingers. When asked if she ever had sexual intercourse with Employee 3 the resident stated no. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted by the surveyor with Employee 1 on February 13, 2025, at 12:23 PM. Employee 1 stated that on the evening of February 9, 2025, between 7:45 PM and 7:50 PM, she began passing out nighttime snacks to residents. When she arrived at Resident 1's room, she noticed that the door was closed, which she found unusual since neither Resident 1 nor her roommate typically closed their door. Employee 1 explained that she knocked lightly and slowly opened the door to avoid hitting anyone who might be walking to the bathroom. Upon entering the room, she observed that the privacy curtain was completely drawn around Resident 1's bed. She first approached Resident 1's roommate, who was on the other side of the room, and handed them a snack. As Employee 1 walked back toward the doorway, she noticed a small opening in the privacy curtain. Looking through the gap, she saw Employee 3 standing near the head of Resident 1's bed. She noted that the bed had been raised to the level of Employee 3's waist and that Resident 1 was lying on her side, propped up with pillows. Employee 1 observed that Employee 3 was holding the blankets up to Resident 1's head, had his hands on the resident's head, and was making thrusting motions toward the resident's face. Employee 1 stated that Employee 3 appeared focused on what he was doing and did not immediately realize she was in the room witnessing the interaction. When Employee 3 finally noticed her, he quickly pulled away and moved down from the resident's face. Employee 1, feeling scared and shocked by what she had just witnessed, immediately threw the snack she was holding onto the resident's bed, exited the room, and sought out Employee 2 RN for assistance. Employee 1 further stated that after she reported the incident, Employee 2 RN promptly removed Employee 3 NA from the building, and law enforcement was contacted. On February 13, 2025, at approximately 2:00 PM, a surveyor conducted an in-person interview with Employee 4 (NA). During the interview, Employee 4 stated that on February 9, 2025, she was working on the nursing unit alongside Employee 1. While charting at the time, Employee 1, who was visibly shaken, pale, and teary-eyed, approached her and asked for assistance in finding a supervisor. Employee 4 recalled that while riding the elevator, Employee 1 explained that when she entered Resident 1's room to distribute nighttime snacks, she witnessed a disturbing incident. According to Employee 1, upon entering the room, she saw that Employee 3 had propped up Resident 1 with pillows. Employee 1 described that Employee 3 was making thrusting motions at Resident 1's face while as he was receiving oral sex. After hearing this, Employee 4 NA and Employee 1 NA located Employee 2 RN on the second floor and informed him of what had occurred. Employee 4 NA reported that Employee 2 RN then went downstairs to investigate while she and Employee 1 NA stayed upstairs to document witness statements. When asked if she had ever observed any interactions between Resident 1 and Employee 3 NA before, Employee 4 NA indicated that she had seen Resident 1 make sexual and inappropriate comments to Employee 3 NA on prior occasions. Although she found these interactions unusual, she mentioned that she would correct Resident 1 by telling her it was inappropriate to talk to men that way. Additionally, Employee 4 NA noted that Employee 3 NA was not assigned to Resident 1 on the night of the incident, and there was no reason for him to be in her room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was also attempted with Employee 3 on February 13, 2025, at 2:22 PM. However, after calling his number twice, the line indicated the number was no longer in service. A telephone interview was completed on February 13, 2025, at 2:24 PM by the surveyor, Employee 5, a licensed practical nurse (LPN), stated that on February 9, 2025, she was working as the unit nurse while the Superbowl was airing, with residents gathered in the dining room under her supervision. She reported that she did not witness any sexual encounter that night. However, upon leaving the dining room, she noticed Employee 1, who appeared extremely distraught. When she asked Employee 1 NA what had happened, Employee 1 explained that Resident 1 had told her she witnessed Employee 3 NA receiving oral sex from Resident 1. Employee 5 LPN added that she and Employee 2 RN then went to speak with Resident 1. During that conversation, Resident 1's account was inconsistent-at times stating she was merely touching Employee 3's head and neck, and at other times claiming she had not touched him at all. Employee 5 also observed that Resident 1 kept wiping her mouth, which she found suspicious. Additionally, Employee 5 reported witnessing Employee 3 being escorted out of the building; he did not speak or ask any questions during his removal. In an interview conducted on February 13, 2025, at 2:57 PM, Employee 2 stated that on February 9, 2025, she was on the second floor when a visibly upset Employee 1-crying and shaking-approached her. Employee 1 informed her that while passing out snacks, she had seen Resident 1's bed raised to the level of Employee 3's waist, with Resident 1's face positioned near Employee 3's genitals as he moved back and forth over her face. Employee 1 noted that Employee 3 became startled when he saw her and quickly moved back. Employee 2 then went downstairs and observed Employee 3 pacing with a red face. She confronted him, told him he had to leave, and escorted him out of the building. When she asked him what had happened in the foyer, Employee 3 claimed that nothing had occurred, and that the interaction was consensual before leaving. Employee 2 further stated that she later discussed the incident with Resident 1 who was evasive and maintained that nothing had happened. Witness testimony and investigative reports confirmed that Employee 3 had engaged in prior sexual encounters with Resident 1, including inappropriate touching and penetration, which were undiscovered by facility staff. Despite initial denials, Resident 1 later confirmed that Employee 3 initiated sexual interactions and had been engaging in sexual contact with her for approximately one month. Interviews with multiple employees confirmed that Employee 1 was visibly distressed after witnessing the abuse and immediately reported the incident. Employee 3 was removed from the building that night but was able to engage in sexual activity with a resident without detection prior to this incident. The facility failed to ensure that residents were protected from sexual abuse by facility staff. Employee 3 was in a position of power and engaged in repeated sexual abuse of a resident, violating the resident's rights, dignity, and safety. The facility did not prevent or detect the abuse, placing all residents at risk for further harm. The failure to recognize, report, and intervene in a timely manner led to Immediate Jeopardy, which was identified on February 13, 2025, at 1:45 PM due to the facility's failure to prevent abuse and protect the residents beginning on February 9, 2025, at 7:45 PM when Resident 1 and Employee 3 were observed in a sexual act. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's immediate action plan dated February 13, 2025, indicated that the following actions would be taken: 1. An internal investigation was immediately initiated on February 9, 2025. 2.The employee who left the resident with the perpetrator was suspended on February 10, 2025. 3.The accused perpetrator was removed in the facility on February 9, 2025. 4. The nursing agency was notified of the alleged accusation towards their employee on February 10, 2025. 5. The abuse policy will be reviewed and revised which was completed on February 13, 2025. 6. The facility staff will be educated on the abuse policy and procedure, protecting resident safety which includes remaining with the resident, and guidelines on preserving an investigative scene prior to the start of their shift in person or via telephone beginning on February 12, 2025. Further no staff will be permitted to work until this education has been completed. 7. The facility immediately completed resident interviews with those residents with BIMS of 12 and above to determine if any other residents were affected on February 10, 2025. 18.The facility assessed residents with BIMS under 12 for signs of abuse on February 13, 2025. 9. The QAPI Committee will reconvene on February 14, 2025, to review the root cause of the noncompliance. 10. The NHA or designee we'll take a random sampling of residents an interview them to determine if any abuse has occurred and if appropriate steps were followed. Audits will occur daily until further direction beginning on February 14, 2025. Further a random sampling of employee interviews will be completed to ensure they know how to identify and respond to abuse. These audits will occur daily until further direction beginning on February 14, 2025. Following verification of the implementation of the corrective action plan the Immediate Jeopardy was lifted at on February 13, 2024, at 5:15 PM. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41581 Based on select facility policy and staff interview it was determined the facility failed to fully develop and implement an abuse prohibition policy that includes specific procedures to fulfill the requirement of fully identifying and investigating abuse. Findings include: A review of a facility policy entitled Abuse and Neglect Prevention revealed it is 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. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. Further it is indicated every resident has the right to be free from verbal, sexual, physical, and mental abuse. The facility policy includes components addressing: Screening Training Prevention Identification Investigation Protection Reporting/Response. Under the area of identification, the policy indicates in the event of a suspected maltreatment, the needs of the resident will be immediately assessed, and the safety of the resident will be insured. The safety and health of the resident will be attended to before any other action is taken. Immediate steps should be taken to ensure that no resident remains in danger of maltreatment, including medical intervention as needed. However, the facility's policy failed to include written procedures to assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. Specifically, the policy does not provide guidance on recognizing different types of abuse, such as: Mental/verbal abuse Sexual abuse (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical abuse Deprivation of goods and services Under the area of investigation, the policy indicates upon receiving a complaint of alleged maltreatment, the administrator must be notified immediately and they, the director of nursing, or assigned designee will coordinate an investigation which will include completion of witness statements. When a specific staff member is implicated in the alleged event, the person will be removed from the resident care area immediately, interviewed by the supervisor assigned, asked to provide a written statement, and suspended until the investigation is completed. However, the facility's policy failed to include procedures specific to the handling of evidence in cases of sexual abuse. The policy does not state that the facility must conduct its investigation without tampering with evidence, which could interfere with a thorough investigation by the facility and external authorities. Examples of tampering include, but are not limited to: Washing linens or clothing Destroying documentation Bathing or cleaning the resident before a forensic examination (including a rape kit, if appropriate) Otherwise impeding a law enforcement investigation An interview with the Nursing Home Administrator on February 13, 2025, at approximately 11:00 AM confirmed the facility failed to fully develop and implement an abuse policy that ensures proper identification and investigation of abuse allegations. Failure to include these provisions in the facility's abuse prohibition policy increases the risk of incomplete investigations and failure to protect residents from further harm. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services 28 Pa. Code 201.29 (a)(c)Resident Rights 28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of select facility policy, facility investigative reports, clinical records and staff interviews it was determined the facility failed to ensure a complete and accurate investigation into sexual abuse was completed for one resident out of 6 sampled (Resident 1). Findings included: A review of a facility policy entitled Abuse and Neglect Prevention revealed it is 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. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. Further it is indicated every resident has the right to be free from verbal, sexual, physical, and mental abuse. Further review of the facility abuse policy revealed under the area of investigation when the facility receives a complaint of alleged maltreatment, the administrator must be notified immediately and they, the director of nursing, or assigned designee will coordinate an investigation which will include completion of witness statements. All parties involved including staff residents or visitors who were potentially involved or observed the alleged incident are to be interviewed by the director of nursing, director of social services, or their designees. When a specific staff member is implicated in an alleged event, the person will be removed from the resident care area immediately interviewed by the supervisor assigned and ask to provide a written statement. Under the area of protection of residents during an investigation the facility should remove the resident from the situation and examine and interview the resident immediately to ensure there is no injury. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD a group of lung diseases that cause ongoing breathing problems), type 2 diabetes (high blood sugar), and muscle wasting. A review of a Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 7, 2024, revealed that the resident was cognitively intact with a BIMs score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). A review of the facility's investigation report dated February 9, 2025, at 7:45 PM revealed that Employee 1 (Nurse Aide) reported to Employee 2 (Registered Nurse) an inappropriate sexual encounter between Resident 1 and Employee 3 (Nurse Aide). The report indicated that Resident 1 was assessed, and no injuries were found. Employee 3 was escorted from the facility, and Resident 1 declined transfer to a hospital for evaluation. A witness statement from Employee 1 dated February 9, 2025, described the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 1 was passing out snacks when she knocked on Resident 1's closed door. Upon entering, she observed Employee 3 receiving oral sex from Resident 1. Resident 1's bed was raised to Employee 3's waist height, with the resident lying on her left side. Employee 3 was holding the resident's head and shoulders while moving back and forth. Employee 3 appeared startled when he noticed Employee 1 and quickly moved away from the resident. A statement from Employee 3, obtained via telephone on February 10, 2025, provided a conflicting account: Employee 3 claimed he was performing a routine walk-through on the unit and noticed Resident 1's dinner tray still in the room. He stated that the resident appeared uncomfortable, so he turned her onto her side and placed a pillow behind her back. He reported that Employee 1 quietly entered the room, placed a sherbet on the bed, and then left. Employee 3 stated that after adjusting Resident 1, he fed her the sherbet and then exited the room, at which point he was told he needed to leave the facility. A review of a statement dated February 10, 2025, revealed the resident was questioned about the incident that occurred. Resident 1 was asked what had occurred the night before and asked if she was in a relationship with Employee 3. The resident stated he was married but she did give him oral sex the night before. The resident indicated it was not the first time she had seen his genitals. The resident stated in the past Employee 3 had touched her genitals and oral sex occurred once before. A statement from Employee 4 (Nurse Aide) dated February 9, 2025, indicated that she did not witness the incident but last saw Resident 1 in bed at 6:30 PM. The facility failed to conduct a thorough and complete investigation by neglecting to interview and obtain statements from all staff members present in the unit during the incident. This includes: Employee 5 (Licensed Practical Nurse - LPN) Employee 2 (RN Supervisor) Both individuals were potentially involved or could have been witnesses to the events that transpired. Their accounts could have provided crucial information regarding the timeline of events and staff awareness of Resident 1's interactions with Employee 3. An interview conducted with the Nursing Home Administrator and Director of Nursing on February 13, 2025, at approximately 5:30 PM confirmed that the facility's investigation into the sexual abuse of Resident 1 was incomplete (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41581 Based on a review of clinical records, select investigative reports, and employee job descriptions and staff interview it was determined the facility's administration failed to effectively use its resources to promote resident safety and maintain the highest practicable physical and mental functioning of residents in the facility by failing to prevent the sexual abuse of one resident (Resident 1) out of 6 sampled residents. Findings included: A review of the job description for the nursing home administrator (NHA) signed and dated on February 1, 2025, revealed the administrator manages all business-related activity to achieve the facility's vision and supporting strategies and assures that the company's image as an ethical and high-quality provider of healthcare services is maintained. The essential job functions include the following: Know and respect patient rights. Ensure resident concerns and complaints are responded to with tact and urgency. Reports allegations of resident abuse, neglect, and or misappropriation of resident property. Follows established safety policies and procedures. Ensures potential safety and health hazards are eliminated. Direct the location of staff to provide high quality in daily care which meets and exceeds all standards within budget parameters. Intervenes as appropriate with potentially threatening situations and follows up with staff after the crisis has been resolved. Organizes the functions of the nursing home throughout appropriate departmentalization and the delegations of duties. Establishes formal means of accountability. Manages safety according to procedures and guidelines and ensures that potential safety health hazards are eliminated or controlled through regular reviews of work activities and materials. A review of the job description for the director of nursing (DON) signed and dated on February 1, 2025, revealed the director of nursing works with the administrator and directs the nursing department to maintain quality standards of care in accordance with current federal, state, and the facility standards guidelines and regulations. In the absence of the administrator, the director of nursing assumes the responsibility for center operations. The position conducts the nursing process, assessment, planning, implementation, and evaluation under the scope of the states nurse practice act of registered nurse licensure. The essential job functions include the following: Reports complaints made by the resident to the supervisor. Reports allegations of patient abuse, neglect, and or misappropriation of resident property. Follows established safety policies and procedures. Observed safety needs of patients as indicated in their care plan. Participates in and promotes resident rights and customer service programs. Understands and promotes the federal, state, and company position on abuse and neglect prevention. Ensures ethical care delivery with adherence to corporate compliance and safe business practices. Freedom from Abuse, Neglect, and Exploitation revealed that the administrator and director of nursing failed to fulfill the essential job duties for ensuring the safety of the residents and adherence to regulatory guidelines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395344	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Greenwood Hill	420 Pulaski Drive Pottsville, PA 17901

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Deficiencies cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F600 F607 F610) 483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation, 483.12(b) The facility must develop and implement written policies and procedures that 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, 483.12(b)(2) Establish policies and procedures to investigate any such allegations, and 483.12(b)(3) Include training as required and 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. 483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. 483. 12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken, revealed the NHA and DON failed to fulfill the essential job duties for ensuring the safety of the residents and adherence to regulatory guidelines. Cross refer F600, F607, F610 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (e)(1) Management 28 Pa. Code 211.12 (c) Nursing services