| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395344 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edenbrook of Greenwood Hill | 420 Pulaski Drive<br>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 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>(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 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and documentation provided by the facility, observations, and staff interviews, it was determined that the facility failed to develop, revise, and consistently implement an individualized, person-centered plan of care to identify, prevent, and manage dementia-related behaviors for one resident out of eight residents sampled (Resident 1). Findings include: A review of the clinical record revealed Resident 1 was admitted on [DATE], with diagnoses that included cerebral infarct (a stroke caused by interrupted blood flow to the brain) and alcohol-induced persisting dementia (long-term cognitive impairment resulting from chronic alcohol use causing permanent brain damage). A review of an quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 25, 2025, revealed Resident 1 was moderately cognitively impaired with a BIMS score of 9 (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 8-12 indicates moderately, cognitively impaired). A review of the resident's care plan revealed a problem addressing behavioral symptoms was initiated on October 2, 2025, identifying behaviors that included cursing at staff, resisting care, noncompliance with transfers, statements wishing she was dead, and wandering into other residents' rooms. Interventions listed included placing a name sign outside the resident's room, identifying broad behavioral triggers, one-to-one conversation, offering cooling-off periods or naps, administering medications, and anticipating needs. The care plan lacked specific, individualized, and actionable interventions tailored to the resident's repeated aggressive behaviors, unsafe wandering, and escalation toward residents, staff, and visitors. Further review of the resident's Activities of Daily Living (ADL) care plan initiated June 3, 2025, indicated the resident required assistance of one staff member for ambulation with a rolling walker. Despite this, nursing documentation throughout September and October 2025 repeatedly reflected the resident ambulating independently throughout the unit during episodes of agitation and behavioral escalation, without evidence the care plan was revised to address safety risks or supervision needs. A review of nursing documentation revealed that beginning in September 2025, Resident 1 demonstrated a pattern of escalating dementia-related behaviors, including repeated verbal aggression, inability to be redirected, wandering into other residents' rooms, and threatening or unsafe actions:September 4, 2025, at 7:21 AM:Nursing documentation reflected that during the prior 11:00 PM to 7:00 AM shift, Resident 1 was observed going through her roommate's personal belongings. Staff redirected the resident multiple times during the shift, after which the resident became angry and yelled at staff. Later the same day, the Social Services Director met with Resident 1 to discuss personal space. During that interaction, Resident 1 stated she was missing a box and reported she was only searching for it. The resident denied yelling at staff.September 13, 2025, at 4:02 PM:Resident 1 was observed yelling at her roommate and stating, Get this thing out of here. Staff removed Resident 1 from the room and escorted her to the dining room to de-escalate the situation. Resident 1 requested a room change due to ongoing conflict with her roommate. The responsible party was notified and agreed to the room change. Resident 1's was changed. September 21, 2025, at 6:37 AM:Nursing documentation indicated that during the 11:00 PM to 7:00 AM shift, Resident 1 exited her room into the hallway multiple times yelling for staff assistance. When staff approached, the resident became verbally combative. Documentation reflected the resident was disruptive to other residents who were sleeping on the unit and was unable to be redirected. September 26, 2025, at 12:31 PM:Resident 1 was documented as ambulating independently out of her room while yelling for help and being verbally abusive toward staff and other residents. The resident's verbal abuse toward staff was again documented during the month of October 2025.October 7, 2025, at 1:43 PM:During the lunch meal, Resident 1 stated, If I had a gun, I would kill myself, after expressing dissatisfaction with the food on her lunch tray. Nursing staff remained with the resident in her room for a documented cooling-off period. Documentation indicated the resident had previously been seen by contracted psychiatric services. The note identified the resident as her own responsible party; however, the clinical record reflected the resident's niece was the responsible party. The responsible party was not contacted or notified of the incident. Interventions documented at the time included encouraging the resident to use deep breathing techniques to calm herself and to talk with staff when issues were bothering her. October 11, 2025, at 4:05 AM:Resident 1 was observed on her roommate's side of the room repeatedly shutting the window after the roommate asked |