STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	23 Ellen Memorial Lane Honesdale, PA 18431

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 - Actual harm 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** Based on a review of clinical records, the facility's abuse prohibition policy, facility investigative documentation, and staff interviews, it was determined the facility failed to ensure that a resident was free from neglect by not providing care with the required assistance of two staff members and the use of a mechanical lift as planned to ensure safety and prevent major injuries. As a result, the resident sustained a fracture of the ankle with actual harm for one out of five residents reviewed (Resident CR1). This deficiency is cited as past noncompliance.Findings include: A review of a facility policy titled Abuse, adopted by the facility on December 1, 2025, revealed the residents at the facility have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when a facility is aware of or should have been aware of goods and services that a resident requires but the facility fails to provide them to the resident that has resulted in or may result in physical harm, pain, mental anguish or emotional distress including failure of staff to implement resident interventions identified on the care plan. A review of the closed clinical record revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses, including, right sided hemiplegia/hemiparesis (paralysis or weakness affecting one side of the body) following a cerebral infarct (stroke, a condition in which blood flow to part of the brain is interrupted causing brain cell damage). A review of Resident CR1's quarterly Minimum Data Set Assessment, (MDS, a federally mandated standardized assessment process completed periodically to plan resident care) dated December 9, 2025, revealed the resident was independent with activities of daily living to include transfers, ambulation and toileting. The MDS revealed the resident was cognitively intact as evidence by 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 13-15 indicates cognitively intact). Review of the individualized care plan-initiated January 8, 2025, revealed Resident CR1 had a self-care deficit related to hemiplegia, imbalance, limited mobility, and limited range of motion (the extent to which a joint can move in different directions, including bending and straightening, which reflects flexibility and functional movement ability). Interventions at that time indicated the resident was independent with a roller walker (a wheeled walking device used for stability) for transfers and ambulation. Review of therapy documentation dated March 11, 2026, revealed Resident CR1 was reevaluated March 6, 2026, following a decline in functional mobility (ability to move safely and independently) and complaints of increased left hip pain. Documentation indicated the resident had recently refused attempts to stand and requested use of a standing lift for transfers. A therapy progress note dated March 9, 2026, indicated the resident remained in bed and declined to attempt standing. The therapist documented education provided to the resident regarding the importance of mobility and determined the resident's assistance level required a downgrade from independence with rollator walker to a standing lift (sit-to-stand lift, a mechanical assistive device used to help a person (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 0600 Level of Harm - Actual harm Residents Affected - Few	who can bear some weight safely move from a sitting position to a standing position with staff support, reducing the risk of injury to the individual and caregiver) due to inability to assess safe ambulation and transfers. Resident CR1 was not concerned with being changed to a stand-up lift despite previously being independent. Review of Resident CR1's care plan dated March 9, 2026, revealed updated interventions requiring use of a stand-up lift for transfers with assistance of two staff members and ambulation with a roller walker and gait belt (a safety belt placed around the waist to assist with balance support during walking) with assistance of two staff members. There was no Kardex report (a report that indicates the date when interventions were added to the Kardex, which is a quick reference for staff that includes a summary of resident required care information) regarding the resident's care needs at the time of the incident available to the survey team for review at the time of the survey. A nursing progress note dated March 13, 2026, at 4:00 PM documented Resident CR1 experienced a witnessed fall in the bathroom while ambulating with one nurse aide and using a roller walker. Documentation indicated the resident fell while turning to sit on the toilet and was found sitting on the floor with the left foot twisted backward at the ankle. The resident complained of ankle and foot pain. The physician was notified and ordered transfer to the hospital for evaluation and treatment. Hospital documentation dated March 13, 2026, indicated the resident was evaluated and underwent X-ray imaging (a diagnostic test using radiation to visualize bone structures). Imaging revealed a comminuted fracture (a break in which the bone is splintered into multiple pieces) of the medial malleolus (inner bony prominence of the ankle) and a laterally displaced oblique fracture (a diagonal break in the bone that has moved out of normal alignment) of the lateral malleolus (outer bony prominence of the ankle). The impression was medial and lateral malleolar fractures of the left ankle. Hospital documentation indicated that the resident received narcotic pain medication (strong prescription medication used to treat severe pain) and a splint (rigid support used to immobilize an injured body part) and wrap were applied. The resident returned to the facility on March 13, 2026, at 7:38 PM with a diagnosis of closed bimalleolar fracture (fracture involving both sides of the ankle joint without an open wound). Physician orders included splinting the left ankle at all times, non-weight bearing, total mechanical lift with assistance of two staff members for transfers and follow-up with an orthopedic surgeon (a physician specializing in treatment of bone and joint conditions), and administration of pain medication as needed.A review of a nurse's notes dated March 17, 2026, at 12:27 PM revealed that Resident CR1 left the facility for an appointment with the Orthopedic Surgeon at 10:30 AM. The resident was transferred into the wheelchair via a total mechanical lift with her left leg splint in place. A review of the consultation report and corresponding physician orders dated March 17, 2026, revealed that Resident CR1 had a closed, displaced fracture of the lateral malleolus of the left tibia (left ankle fracture). The note indicated that surgical intervention was required for this resident. The note also stated that medical clearance was required prior to surgery. A nurse's note dated March 19, 2026, at 8:13 PM revealed Resident CR1 was medically cleared for surgery. Surgery was scheduled for March 27, 2026. The resident had an additional orthopedic presurgical visit on March 25, 2026, at 1:04 PM. A review of the consultation report dated March 25, 2026, revealed that the reason for the consultation was a left bimalleolar ankle fracture. A review of an orthopedic consultation report dated March 25, 2026, revealed that the resident was examined and her history reviewed. Surgical and nonsurgical treatments were discussed with the resident. The note stated, Given the unstable nature of the bimalleolar ankle fracture, discussed and recommended surgical intervention to include, left lower extremity ORIF (open reduction internal fixation, surgical intervention to repair the fracture) of the left ankle. The resident agreed to surgery at that time. According to nursing progress documentation Resident CR1 was transferred to the hospital on March 27, 2026, at 6:15 AM for surgical repair and returned to the facility on March 27, 2026, at 5:37 PM following ORIF surgery of the left ankle. Review of a facility-provided investigative document dated March 13, 2026, included a written statement from Employee 1, Nurse Aide. In the written statement, Employee 1 documented she responded to Resident CR1's call bell requesting (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	assistance to the bathroom. Employee 1 documented that another nurse aide (Employee 2, Nurse Aide) told the resident to prove herself (demonstrate her ability) by using the walker. Employee 1 documented that she told the resident, That is not the way you transfer anymore; however, the resident insisted on using the walker. Employee 1 documented that the resident was ambulating with the walker until the resident turned to sit on the toilet and began to fall. Employee 1 documented that as the resident was actively falling, she leaned against the resident's body in an attempt to guide her safely to the floor. Employee 1 documented that the resident landed sitting on her left foot and that she was unable to move from under the resident, at which time she called out for assistance. Review of a facility-provided witness statement dated March 13, 2026, from Employee 2, Nurse Aide documented that at the beginning of her shift she received report from nursing staff and began responding to call bells. Employee 2 documented that she entered Resident CR1's room and asked the resident, Hey do we plan on using the toilet today? I would like you to try since you were incontinent yesterday. Employee 2 documented that the resident responded, I will, but I don't feel like going right now. Employee 2 documented she responded, ok, let us know, and then continued answering call bells and performing assigned duties. During a telephone interview conducted by the surveyor on March 31, 2026, at 12:11 PM Employee 1, Nurse Aide, confirmed she was aware of Resident CR1's transfer and ambulation status at the time of the fall. Employee 1 stated that Resident CR1 told her that Employee 2, Nurse Aide, instructed the resident that she had to prove herself by ambulating to the bathroom. Employee 1 stated that she knew the resident's transfer status required assistance of two staff members with use of a stand-up lift for transfers and ambulation with a roller walker and assistance of two staff members. Employee 1 stated the resident was transferred and ambulated without the required level of assistance, resulting in a fall with injury requiring surgical intervention. Employee 1 stated she was suspended and sent home immediately following the incident and her employment was terminated on March 16, 2026. During a telephone interview conducted by the surveyor on March 31, 2026, at 12:30 PM Employee 2, Nurse Aide, stated that on March 13, 2026, at 4:00 PM, she entered Resident CR1's room at the start of her shift to encourage the resident to request staff assistance when ready to use the bathroom. Employee 2 denied pressuring the resident or encouraging the resident to ambulate or toilet independently. Employee 2 stated she was suspended and sent home at the time of the incident. Employee 2 stated that following completion of the facility's investigation, she returned to work on March 16, 2026. Review of Employee 1's personnel file revealed the employee completed training, including abuse and neglect prevention, safe bed mobility procedures, safe transfer and lift techniques, and documentation requirements within the electronic health record, with attestation signed March 11, 2026. During an interview on March 31, 2026, at 1:00 PM, the Nursing Home Administrator confirmed the facility investigation determined Employee 1 did not follow Resident CR1's care plan requiring assistance of two staff members for ambulation and transfers. The Nursing Home Administrator confirmed Employee 1 was removed from the schedule pending investigation and employment was terminated March 16, 2026. The facility implemented corrective actions immediately following the incident. The resident was assessed and transferred for medical evaluation. Employees 1 and 2, Nurse Aides, were suspended pending investigation. The facility reviewed all resident records to verify transfer and ambulation requirements were accurately reflected in care plans and Kardex reports. Nursing staff received re-education regarding adherence to individualized care plans and neglect prevention requirements. To sustain compliance, nursing administration implemented observational audits to ensure staff compliance with transfer requirements. Audits were conducted three times weekly for four weeks, weekly for four weeks, and monthly thereafter. Audit results were reviewed through the Quality Assurance Performance Improvement (QAPI, a program that monitors and improves quality of care and services) committee to determine ongoing compliance needs. The facility achieved substantial compliance on March 16, 2026. This deficiency is cited as past noncompliance. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 201.18 (e)(1) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services.