STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395361	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Ridge Manor East/West	8300 West Ridge Road Girard, PA 16417

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility policy, clinical records, and facility documents, and staff interviews, it was determined that the facility failed to ensure all alleged violations involving abuse were reported in a timely manner for one of six residents reviewed (Resident R1). Findings include: Review of facility policy entitled Abuse - Reasonable Suspicion of a Crime - Prevention / Reporting dated January 2024, revealed the facility will not tolerate any form of abuse, exploitation, mistreatment or neglect of its residents, nor will it tolerate misappropriation of residents' funds or property by anyone. All covered individuals shall report any incident or suspicion of abuse, neglect, mistreatment, or misappropriation of funds or property immediately to the Abuse Coordinator (Director of Human Resources), Director of Nursing, or the Administrator / Executive Director, or in their absence to the RN Supervisor, or Charge Nurse. The policy further states for Protection, Identification, and Reporting that The Administrator / Executive Director, the Director of Nursing, and the Abuse Coordinator, must be informed as soon as possible of alleged abuse, neglect, mistreatment, or misappropriation of resident funds or property. The policy Process revealed that when an employee has reasonable cause to suspect that a resident is a victim of abuse, neglect, exploitation or abandonment, the employee shall report it to their supervisor, who will immediately report it to the facilities Executive Director, Director of Nursing, or Abuse Coordinator, and that staff will complete a Star Witness Report indicating the time, location, resident, and details of the allegation and submit it to the supervisor prior to the completion of his/her shift. Facility policy defines Physical Abuse as including, but not being limited to hitting, slapping, kicking, biting, spitting, or throwing items, etc. Abuse, is defined at §483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R1's clinical record revealed an admission date of 4/21/16, with diagnoses that included dementia (loss of cognitive functioning affecting a person's memory and behaviors), tracheostomy(a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing), and diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R1's quarterly Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care) with an Assessment Reference Date (ARD) of May 22, 2025, revealed Resident R1 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairments. Review of information submitted by the facility dated 5/22/25, identified that there was an incident during the end of the third shift the morning of 5/21/25, between 6:00 a.m. and 7:00 a.m. during a transfer using a mechanical lift with Resident R1, where NA Employee E6 pulled the resident's fingers off the lift and bent them backwards. NA Employee E6 was also observed to punch and pinch the resident while in the lift and in the wheelchair. NA Employee E4 told NA Employee E6 to stop, and he/she replied, You will shut up, you didn't see anything. NA Employee E4 went to report the incident and did not see their nurse before leaving their shift to report the event and therefore did not report the incident immediately before leaving the facility. The occurrence of the incident was not discovered until 5/22/25, at 7:40 a.m. when the Director of Nursing received a call regarding an allegation of resident abuse. The facility immediately initiated an investigation. During an interview on 6/10/25, at 2:00 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON) and the Assistant Director of Nursing (ADON), they acknowledged that there was a delay in reporting the aforementioned allegation of abuse as the incident occurred on 5/21/25, at 6:15 a.m. and the DON was not notified until 5/22/25, at 7:40 a.m. The NHA, DON, and ADON also confirmed that staff are to report suspected allegations of abuse immediately. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services