

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2025
NAME OF PROVIDER OR SUPPLIER Edenbrook North		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Leader Drive Williamsport, PA 17701	

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 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. (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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate and report to the appropriate agencies an injury of unknown origin and potential neglect for one of seven records reviewed (Resident CR1). Findings include: The policy entitled Injury of Unknown Origin, last reviewed without changes on February 1, 2025, revealed it is the policy of the facility to immediately investigate all injuries of unknown origin to determine the cause, ensure resident safety, and comply with federal and state reporting requirements, including mandatory notifications to the Department of Health. The nurse discovering or notified of the injury must perform an assessment including pain, location, size, color, and pattern of injury. The attending physician or on-call provider will be notified promptly for evaluation and treatment orders. The facility will remove the resident from potential harm if indicated and ensure supervision until the resident's safety is assured. The Director of Nursing and Nursing Home Administrator will be notified immediately. The responsible party will be notified promptly of the injury and findings. If abuse, neglect, or misappropriation is suspected, the incident must be reported within two hours if there is serious bodily injury, or within 24 hours to the Department of Health. The Director of Nursing or designee initiates a root cause investigation reviewing staffing assignments, supervision, and the environment. Interviews with residents, staff, and potential witnesses and review of recent events will be completed. The Director of Nursing or designee will evaluate potential abuse, neglect, or accident-related causes, including the abuse coordinator when abuse cannot be ruled out. The facility will complete and submit investigation results within five business days to the Department of Health. Closed clinical record review revealed the facility admitted Resident CR1 on October 29, 2020. Nursing documentation dated October 12, 2025, at 10:08 AM revealed hospice was contacted for further instructions on Resident CR1's condition with bruising to her forehead. Documentation at 10:17 AM revealed the certified nurse practitioner noted that Resident CR1's forehead was raised and discolored, she also noted a bruise to Resident CR1's right hand. Documentation dated October 13, 2025, at 12:35 AM noted Resident CR1's bruising on her forehead had moved under her left eye. Review of the facility investigation dated October 12, 2025, at 6:00 AM revealed that Resident CR1 was found with a discolored area and swelling on her forehead on October 11, 2025 (second shift). Resident CR1 stated she fell and was picked up off the floor. The registered nurse assessed and found erythema (redness or discoloration of skin) on her forehead. Review of Employee 1's (nurse aide) witness statement dated October 12, 2025, indicated yesterday when Employee 1 was giving Resident CR1 a shower he saw a bruise around her head and hand, but did not report it immediately. Employee 1 noted in the morning when he was washing her up, the bruise got worse, so he notified the licensed practical nurse. When the nurse asked Resident CR1 what happened Resident CR1 said she fell yesterday, but she could not remember who picked her up. Further review of Resident CR1's clinical record revealed a significant change MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated September 26, 2025, noting staff assessed Resident CR1 as dependent on staff for all activities of daily living. Interview with the Director of Nursing on November 8, 2025, at 1:37 PM confirmed these findings. She stated it is the facility policy for staff to report all injuries of unknown origin at the time of identification. The facility failed to thoroughly investigate and report to the appropriate authorities Resident CR1's bruises to rule out neglect or prevent further injuries. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights</p>		