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 03/09/2026
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. 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 an allegation of potential misappropriation of resident property for one of two records reviewed (Resident CR2). Findings include: The current facility policy entitled Vulnerable Adult Abuse and Neglect Prevention, revealed the facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of an allegation. Upon receiving a complaint of an alleged maltreatment, the Nursing Home Administrator and Director of Nursing must be notified immediately, and they 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. If it appears that the maltreatment may involve a crime, immediately notify the police. The facility will notify the resident's responsible party, as well as physician as soon as possible. The investigation and written findings are completed and reviewed with the Administrator, Director of Nursing, and Director of Social Services. A plan for further action is determined with input from appropriate personnel. The facility must report to the state agency no later than 24 hours if the alleged violation involves neglect, misappropriation of resident property, or exploitation and involves not serious bodily injury. 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. Review of documentation provided by the facility revealed that Resident CR2's responsible party sent Employee 1 (social worker) an email on January 28, 2026, questioning what happened to Resident CR2 to cause the serious bruising to his left arm. The email included pictures of the bruising to Resident CR2's arm. Review of Resident CR2's clinical record revealed there was no documentation of Resident CR2's bruising to his left arm. Interview with the Nursing Home Administrator and Director of Nursing on March 9, 2026, at 7:48 PM revealed the facility did not complete a thorough investigation into Resident CR2's injury of unknown origin due to Resident CR2 stating that he scratched himself. Review of Employee 2's (licensed practical nurse) statement revealed she asked Resident CR2 about the bruises on his arm and he stated he scratched himself and denied anyone grabbing him. Review of Employee 3's (registered nurse) statement revealed she assessed Resident CR2's arm on January 28, 2026, noting a large bruise to his upper forearm. There was no assessment of Resident CR2's bruise in his clinical record, including the size, or color to determine the age of the injury. Review of Resident CR2's weekly skin check completed by facility staff on January 28, 2026, revealed no skin issues. The facility failed to thoroughly investigate and report to the appropriate authorities Resident CR2's bruises to rule out abuse, neglect, or prevent further injuries. Interview with the Nursing Home Administrator and Director of Nursing on March 9, 2026, at 9:03 PM confirmed there was no documentation in Resident CR2's clinical record regarding his injury of unknown origin on January 28, 2026, no assessment of the bruises, or a thorough investigation into the cause of the bruising. Review of Resident Family Grievances provided by the facility revealed a grievance filed by Resident CR2's (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: 395364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook North		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Leader Drive Williamsport, PA 17701	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party on January 15, 2026, noting Resident CR2's prescription glasses were stolen in October, and now personal prescription glasses that the responsible party left at his bedside are now stolen. Resident CR2's responsible party stated the eyeglass case was in his room, but not his glasses. Employee 1(social worker) noted that Resident CR2's responsible party used the words stolen. The grievance investigation noted Employee 1 sent Resident CR2's responsible party a consent for Resident CR2 to be seen by the in-house vision provider. A resolution dated February 5, 2026, revealed the facility requested reimbursement for Resident CR2's glasses when seen by in-house vision provider on the next visit. Further review of Resident CR2's clinical record revealed no investigation into the allegation of the potential misappropriation of Resident CR2's glasses. Interview with the Nursing Home Administrator and Director of Nursing on March 9, 2026, at 8:57 PM confirmed the above findings for Resident CR2. The facility failed to complete an investigation, obtain witness statements, notify law enforcement, or notify Department of Health related to Resident CR2's responsible party's allegation of a potential misappropriation of resident property. 483.12 (b) Development and Implementation of Abuse PolicyPreviously cited deficiency 4/4/25 and 11/8/25 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395364	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook North	300 Leader Drive Williamsport, PA 17701

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of two residents reviewed (Resident CR2).Findings include: Clinical record review revealed the facility admitted Resident CR2 on October 8, 2025. Review of Resident CR2's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated January 14, 2026, noted staff assessed Resident CR2 as dependent on staff for oral hygiene (the ability to use suitable items to clean teeth). Review of Resident CR2's Kardex (documentation system used by staff to organize and reference key resident information essential for resident care) revealed he is to have his teeth brushed twice daily. Review of Documentation Survey Report (electronic documentation completed by nurse aide staff for the completion of ADL care) from January 1 to February 11, 2026, revealed there was no documentation that staff assisted Resident CR2 with oral hygiene twice daily on 18 of 41 days reviewed. There was no documentation indicating staff were providing oral hygiene assistance twice daily to Resident CR2. The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on March 9, 2026, at 9:15 PM 483.24(a)(2) ADL Care Provided for Dependent ResidentsPreviously cited deficiency 4/4/25 28 Pa. Code 211.12(d)(1)(5) Nursing services