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	04/24/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and staff and resident family interviews, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, comfortable, orderly, and homelike environment located in the Central Supply Room, an outdoor storage area behind the dumpsters, and on one of three nursing units (Nursing Units 1; Residents 48, 36, 12, and 84).Findings include: Observations on April 21, 2026, at 7:55 AM revealed the central supply room, which houses a deep freezer and refrigerator for the kitchen, as well as facility supplies, was noted to have a blackened floor around the refrigerator and the freezer. There was dust and debris, in addition to leaves noted on the floor around the entrance area. A wooden pallet on the floor was observed on a blackened floor with dust and debris, including rolled up blue disposable gloves under the pallet. Concurrent observation revealed an area located outside, behind the dumpsters under an awning, with a large pile of furniture items. Included in the pile were two wooden bed frames, a metal bed frame, multiple mattresses, two wooden chairs with cushions on the chairs, and bedside tables. During an interview with Employee 2, Maintenance Director, on April 21. 2026, at 8:05 AM, he stated that the area located behind the dumpsters was an additional storage area, and the items were to be brought back in and used for the residents if needed. Observation on April 21, 2026, at 10:34 AM on the third floor revealed a pair of sneakers, a balled-up pair of gloves, and a blanket, were sitting on the air-conditioning unit located behind chairs at the upper end of the hallway. Observations on April 22, 2026, at 9:18 AM revealed the sneakers, gloves, and blanket were still sitting on the air-conditioning unit behind chairs. Observations on April 21, 2026, at 11:10 AM in the dining room/sunroom area on the third floor revealed the following: A hole in the wall to the left at shoulder height that had a phone jack wire extending four inches from the wall off the entrance to the dining room. The same dining room wall to the left was noted to have multiple splash/drip stains to the lower half of the wall, below the chair rail. There was a balled-up paper towel observed on top of the soda machine in the dining area. The sunroom had four empty wheelchairs in the room with a deflated air mattress on top of them. There was a large purse and a sweater located on one of the wheelchairs. A table in the sunroom had an empty, sealed plastic lunch container with empty ketchup packets and a plastic spoon noted inside. The sunroom ceiling around the windows and the walls were observed to have cobwebs with small dead insects scattered throughout the cobwebs. Cobwebs, debris and dead insects were also noted lining the windowsill. Multiple dark colored objects were observed inside both light fixtures in the sunroom ceiling. The air-conditioning unit in the sunroom was noted to have broken drywall and peeling paint around the top and to the right side of the unit. The above environment concerns regarding the central supply room, outdoor storage, and third floor nursing unit were reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on April 22, 2026, at 2:00 PM. Observation of Resident 48's room on April 22, 2026, at 10:11 AM revealed there was a pile of clothes on the floor in her closet. Observation of Resident 36 and 12's room on April 21, 2026, 11:52 AM revealed there were piles of clothes, as well as hygiene items on the floor of Resident 36 and 12's closets. Interview with Resident 84's family on April 21, 2026, at 2:42 PM revealed that she visits two to three times a week and Resident 84's closet (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	always has clothes on the floor. Observation of Resident 84's closet with her family at this time revealed there were three shirts and a pair of pants on the floor of Resident 84's closet. The above environmental concerns for Residents 48, 36, 12, and 84 were reviewed during a meeting with the Nursing Home Administrator and Director of Nursing on April 22, 2026, at 2:00 PM 483.10(i)(1)-(7) Safe/clean/comfortable/homelike EnvironmentPreviously cited deficiency 4/4/2025 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition for three of seven residents reviewed (Residents 7, 84, and 82).Findings include: Clinical record review for Resident 82 revealed that the facility admitted the resident on February 13, 2026. Further review of Resident 82's clinical record revealed the following weight assessments: February 13, 2026, 110.0 poundsFebruary 24, 2026, 107.0 poundsMarch 2, 2026, 107.0 poundsMarch 11, 2026, 101.0 pounds (a 9-pound, 8% severe weight loss in less than 30 days)March 17, 2026, 100.6 poundsApril 1, 2026, 98.0 pounds Clinical record review revealed a weight change note written by Employee 4, dietitian, dated March 12, 2026, with recommendations to add a house shake. Resident 82 had continued weight loss documented on March 17, 2026, and April 1, 2026. No further review of Resident 82's nutritional status could be identified in the clinical chart. The above findings were reviewed with the Nursing Home Administrator and the Director of Nursing on April 23, 2026, at 2:00 PM. During an interview with Employee 4 on April 24, 2026, at 9:00 AM, they indicated that they had not reviewed Resident 82's weight loss because their name was closer to the end of the alphabet. Clinical record review revealed the facility admitted Resident 84 on August 13, 2025, weighing 170.4 pounds. Interview with Resident 84's family on April 21, 2026, at 2:37 PM revealed that Resident 84 had lost a ton of weight since her admission to the facility. Interview with Resident 84's family revealed that Resident 84 has no issues eating food the family brings in from home but stated that the facility does not serve Resident 84 food according to her preferences. Further review of Resident 84's clinical record revealed the following weight assessments:November 6, 2025, 160.3 poundsDecember 3, 2025, 143.0 poundsDecember 9, 2025, 140.6 pounds (a 19.7-pound, 12.28 percent severe weight loss in a month) Review of a quarterly assessment completed on November 19, 2025, by Employee 4 noted that Resident 84's food and fluid intakes decreased when compared to her prior nutritional review and indicated that Resident 84 met the criteria for being at risk of malnutrition. There were no nutritional interventions added at this time. A weight change note dated December 10, 2025, confirmed Resident 84 had a 19.7-pound, 12.3 percent weight loss in a month, and there were no new nutritional interventions added. Interview with Employee 4 on April 24, 2026, at 10:21 AM, confirmed that no new nutritional interventions were added after the identified December 9, 2025, severe weight loss. Clinical record review revealed the facility admitted Resident 7 on March 27, 2024. Further review of Resident 7's clinical record revealed the following weight assessments: October 2, 2025, 178.8 poundsNovember 3, 2025, 153.8 pounds (a 25-pound, 13.98 percent severe weight loss in a month)November 3, 2025, 154.4 pounds (reweight) Review of a quarterly assessment completed on October 30, 2025, Employee 4 noted Resident 7's food and fluid intake was decreased when compared to the prior nutrition review. Employee 4 noted Resident 7's skin was intact, with no edema noted. A weight change note dated November 4, 2025, confirmed Resident 7's weight was down 24.4 pounds, 13.6 percent weight loss in one month, and there were no new nutritional interventions added. Interview with Employee 4 on April 24, 2026, at 10:07 AM confirmed that no nutritional interventions were added after Resident 7's severe weight loss on November 3, 2025. Employee 4 stated that Resident 7 was on two diuretic medications. Employee 4 confirmed she assessed Resident 7 as having no edema on October 30, 2025, and indicated there were no changes to Resident 7's diuretic medications. The above findings for Residents 84 and 7 were reviewed with the Director of Nursing on April 24, 2026, at 11:03 AM. The facility failed to implement interventions to promote acceptable parameters of nutrition for Residents 84 and 7. S483.25(g)(1) Maintains acceptable parameters of nutritional statusPreviously cited 4/4/25 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation, facility policies and procedures, observation, clinical record review, and review of personnel training records, it was determined that the facility failed to ensure specific competencies necessary to care for resident needs for one of one resident reviewed for intravenous access concerns (Resident 119, Employees 5, 6, 7, 8, 9, and 10).Findings include: The State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, 483.71(c)(1) Facility Assessment, stipulates that the facility must use the facility assessment to inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. The Facility Assessment Tool reviewed during the onsite survey, last reviewed March 31, 2026, revealed that the Resident Support/Care Needs list included types of care the resident population could require and that could be provided. The list noted that specific care or practices for medications required awareness of any limitations of administering medications that residents need by the following routes of administration: oral, nasal, buccal (cheek), sublingual (under the tongue), topical, subcutaneous (under the skin/injection), rectal, intravenous (stipulated peripheral or central lines), intramuscular, inhaled, vaginal, ophthalmic (eye), etc. The facility holds a structured orientation for new hires. During this orientation the staff receive education and competencies on the necessary requirements. If identified, additional training would be provided. Annually, the facility evaluates the educational needs, including competencies, that are needed for staff. The facility policies entitled, Peripherally Inserted Central Line Catheter (PICC), Dressing Change for Vascular Access Devices, and Maintaining Patency of Peripheral and Central Vascular Access Devices, last reviewed March 1, 2026, did not include measures the facility would implement to ensure necessary staff competencies related to PICC line care and use. The facility policy entitled, Maintaining Patency of Peripheral and Central Vascular Access Devices, last reviewed March 1, 2026, noted that if scope of practice regulations do not allow LPNs to flush intravenous catheters and if there is no 24-hour registered nurse coverage in the building, flush protocols may vary to allow for heparin (intravenous anticoagulant medication) flushing by a registered nurse once a day. According to, Pennsylvania Code, Title 49, Chapter 21, Functions of the LPN, an LPN (licensed practical nurse) may perform only the IV (intravenous) therapy functions for which the LPN possesses the knowledge, skill, and ability to perform in a safe manner. Clinical record review for Resident 119 revealed that the facility admitted her on April 18, 2026. Nursing documentation dated April 18, 2026, at 11:28 AM revealed that Resident 119 arrived at the facility for ongoing antibiotic therapy related to her right knee replacement that became infected. admission physician orders dated April 18, 2026, for Resident 119 included the use of the following: PICC line (a long, flexible tube inserted into a vein in the arm that reaches a large central vein near the heart, used for long-term intravenous treatments; the line requires careful care and monitoring for complications including bleeding, infection, and blood clots) to right upper extremityCeftriaxone Sodium (antibiotic) 2 gram intravenously in the afternoon for knee infection Review of Resident 119's Medication Administration Record and Treatment Administration Record (electronic documentation completed by licensed staff to attest to the administration of medications and treatments) dated April 2026 revealed that Employee 5 (licensed practical nurse, LPN), Employee 6 (LPN), Employee 7 (LPN), and Employee 10 (registered nurse), documented that they administered Resident 119's intravenous Ceftriaxone Sodium medication. Employees 8 (LPN) and 9 (LPN) documented that they flushed Resident 119's PICC line with normal saline on their shift. Interview with the Director of Nursing on April 24, 2026, at 8:15 AM confirmed that the facility had no licensed staff competencies completed related to the use of PICC lines. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development 28 Pa. Code 211.12(d)(1) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to monitor target behaviors and potential side effects for psychotropic medication use for two of five residents reviewed for medication regimen concerns (Residents 3 and 6). Findings include: The facility policy entitled, Psychotropic Medication, last reviewed March 1, 2026, revealed that the purpose of the policy was to provide guidance for the psychopharmacologic drug treatment for a resident with a specific condition, including but not limited to dementia and other cognitive disorders, and/or behaviors as documented in the resident's clinical record. An assessment must be conducted to identify specific behaviors/symptoms, potential causative factors and recommendations for managing identified behaviors. The medical record documentation must reflect the specific behaviors/symptoms and the resident's response to non-pharmacological interventions to manage the behaviors/symptoms. After implementation of psychotropic medication, behavior/symptoms and medication side-effects will be monitored and documented. Clinical record review for Resident 6 revealed active physician orders for the following psychotropic medications: Lorazepam (Ativan, an antianxiety medication) 0.5 mg (milligrams) every 12 hours as needed for agitation until April 23, 2026. ABH Gel (Combination topical medication that includes Lorazepam 1 mg, Benadryl (over-the-counter antihistamine that can induce drowsiness) 12.5 mg, and Haldol (an antipsychotic which helps regulate mood, behavior, and thought processes) 1 mg) to wrist topically in the morning for agitation. Resident 6's clinical record did not contain evidence that the facility implemented ongoing monitoring of target behavior symptoms for the use of the antianxiety or antipsychotic medications. Resident 6's clinical record did not contain evidence that the facility implemented ongoing assessment for potential side effects from the use of antianxiety or antipsychotic medications. Review of Resident 6's plans of care developed by the facility to address Resident 6's care needs revealed no interventions related to the use of antianxiety or antipsychotic medications. Interview with the Director of Nursing on April 24, 2026, at 10:04 AM confirmed that the facility had not added Resident 6's antipsychotic and antianxiety medications to her plans of care. The facility could not provide evidence of ongoing tracking of behavioral interventions and the monitoring of potential side effects for the antipsychotic and antianxiety medications. Clinical record review for Resident 3 revealed active physician orders for Aripiprazole (an atypical antipsychotic medication), 2 mg at bedtime for mood regulation. Resident 3's clinical record did not contain evidence that the facility implemented ongoing monitoring of target behavior symptoms for the use of antipsychotic medications. Resident 3's clinical record did not contain evidence that the facility implemented an ongoing assessment for potential side effects from the use of antipsychotic medications. Review of Resident 3's plans of care developed by the facility to address Resident 3's care needs revealed no interventions related to the use of antipsychotic medications. Interview with the Director of Nursing on April 24, 2026, at 12:35 PM confirmed that the facility had not added Resident 3's antipsychotic medication to her plans of care. The facility could not provide evidence of ongoing tracking of behavioral interventions and the monitoring of potential side effects for the antipsychotic medication. 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the residents' representative received written notice of transfer and written notice of the facility bed-hold policy at the time of transfer for one of four residents reviewed for hospitalizations (Resident 1).Findings include: Clinical record review for Resident 1 revealed nursing documentation dated January 11, 2026, at 3:54 AM that Resident 1 was requesting to go to the ER (emergency room) to be evaluated. Resident 1 was transferred to the ER on [DATE], at 4:02 AM and admitted for pneumonia and COPD (chronic obstructive pulmonary disease, a progressive lung disease that makes it difficult to breath). There was no evidence to indicated Resident 1 was provided a written notice of transfer or bed hold information at the time of transfer. Further review revealed Resident 1's was provided and acknowledged a bed hold and transfer notice on January 12, 2026, the day after her transfer to the hospital. There was no documented evidence that the facility provided a copy of the bed hold and transfer notice to Resident 1's responsible party. Interview with the Nursing Home Administrator on April 24, 2026, at 2:45 PM, confirmed that the facility did not provide Resident 1 with a written notice of transfer and bed hold information at the time of transfer nor provide Resident 1's responsible party with a copy of the written transfer or bed-hold notices. 28 Pa. Code 201.14(a) Responsibility of license

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility failed to ensure assessments accurately reflected residents' status for two of 23 residents reviewed (Residents 6 and 9).Findings include: Clinical record review for Resident 6 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated September 4, 2025, that indicated she had range of motion impairment only to one of her upper extremities. A significant change MDS assessment dated [DATE], again assessed her as having range of motion impairment only to one of her upper extremities. A quarterly MDS assessment dated [DATE], assessed that Resident 6 had range of motion impairments to her upper extremity and lower extremity on one side. A quarterly MDS assessment dated [DATE], again assessed her has having range of motion impairments to her upper extremity and lower extremity on one side. Interview with the Director of Nursing and Employee 3 (registered nurse assessment coordinator) on April 24, 2026, at 1:11 PM revealed that the facility determined Resident 6's MDS assessments of September 4, 2025, and November 21, 2025, were incorrect; that Resident 6 should have been coded as lower extremity range of motion impairments on all MDS assessments. The interview indicated that Resident 6 entered the facility with the range of motion deficits and she did not develop a decline as was indicated by the MDS assessments reviewed above. Clinical record review for Resident 9 revealed nursing documentation dated January 23, 2025, at 2:51 PM that Resident 9 arrived from the hospital where she was admitted after she was found with symptoms of left lower extremity and left upper extremity weakness. Nursing documentation dated January 23, 2025, at 8:58 PM revealed that Resident 9 was diagnosed with an acute ischemic right MCA stroke (CVA, brain blood flow interruption that affects the right middle cerebral artery leading to left-sided weakness). Resident 9 had left-sided weakness, confusion, and hallucinations. A quarterly MDS dated [DATE], and a significant change MDS dated [DATE], assessed Resident 9 as having no range of motion impairments. A quarterly MDS dated [DATE], assessed that Resident 9 had upper and lower extremity range of motion impairments on one side. A significant change MDS assessment dated [DATE], assessed Resident 9 had no range of motion impairments. A quarterly MDS assessment dated [DATE], assessed that Resident 9 had upper and lower extremity range of motion impairments on one side. The surveyor requested documentation of the facility's response to Resident 9's decline in range of motion as assessed by her MDS assessments dated December 3, 2025, and March 18, 2026, during an interview with the Nursing Home Administrator and the Director of Nursing on April 22, 2026, at 2:30 PM. Nursing documentation dated April 22, 2026, at 5:02 PM (following the surveyor's questioning) revealed that the facility submitted a modification of Resident 9's February 16, 2026, MDS assessment as it was incorrectly coded to have no impairments with her range of motion when she had impairments on one side due to her CVA diagnosis. Interview with the Director of Nursing on April 24, 2026, at 1:11 PM confirmed that staff incorrectly coded Resident 9's February 16, 2026, MDS assessment. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review and resident and staff interview it was determined that the facility failed to provide the resident and their representative with a summary of the baseline care plan within 48 hours of admission for two of 23 residents reviewed (Residents 119 and 120). Findings include: Clinical record review for Resident 120 revealed that the facility admitted him on April 7, 2026. admission physician orders dated April 7, 2026, for Resident 120 included the use of the following: Supplemental oxygen at three liters per minute continuously every shiftFoley catheter (a flexible tube inserted through the penis into the bladder to drain urine) for failed voiding trials (inability to urinate normally after removal of the Foley)Droplet Precautions in place every shift for a diagnosis of human metapneumovirus (isolation precautions that require the use of masks, gowns, gloves, and eye protection due to a contagious virus that causes respiratory infections)Apixaban 2.5 milligrams (Eliquis, an anticoagulant that can prevent blood clotting and result in abnormal bruising and bleeding) every morning and at bedtime Interview with Resident 120 on April 21, 2026, at 1:38 PM indicated that he did not know what goals he needed to achieve before he could return home or if he would utilize home health services after his discharge from the facility. Resident 120 denied that he received a copy of a care plan since his admission to the facility. Resident 120 stated that he entered the facility following a fall and hip fracture at home for which he was hospitalized and had surgery. Resident 120 utilized supplemental oxygen, had an indwelling urinary catheter (Foley), had pressure ulcer injuries to his bilateral heels, and complained of a sore on his buttocks. Review of Resident 120's plans of care did not reveal any entries related to supplemental oxygen use until April 21, 2026. The surveyor reviewed the above concerns that Resident 120 denied knowledge of his plan of care or his goals during an interview with the Nursing Home Administrator and the Director of Nursing on April 22, 2026, at 2:15 PM. Care plan note documentation created by the facility's activity director dated April 22, 2026, at 4:35 PM (following the surveyor's questioning) revealed that he met with Resident 120 on this date to deliver, review, and have him sign the baseline care plan document. The staff provided Resident 120 a copy. Interview with Employee 1 (registered nurse/unit manager/infection preventionist) on April 24, 2026, at 12:19 PM confirmed that Resident 120's baseline care plan did not include the use of supplemental oxygen despite his physician order for, and use of, since his admission to the facility. Clinical record review for Resident 119 revealed that the facility admitted her on April 18, 2026. Nursing documentation dated April 18, 2026, at 11:28 AM revealed that Resident 119 arrived at the facility for ongoing antibiotic therapy related to her right knee replacement that became infected. The documentation indicated that Resident 119 utilized supplemental oxygen. admission physician orders dated April 18, 2026, for Resident 119 included the use of the following: PICC line (a long, flexible tube inserted into a vein in the arm that reaches a large central vein near the heart, used for long-term intravenous treatments) to right upper extremityCeftriaxone Sodium (antibiotic) 2 gram intravenously in the afternoon for knee infectionSupplemental oxygen at four liters per minute while at rest and eight liters per minute during activity Interview with Resident 119 on April 22, 2026, at 10:31 AM revealed that she denied that she received a copy of a care plan since her admission to the facility. Resident 119 requested that the surveyor look in a folder that she had since her admission to verify that she did not receive the baseline care plan. Resident 119 indicated that she had an intravenous access site in her right bicep area that staff use to administer intravenous antibiotics daily. The surveyor reviewed the above concerns that Resident 119 denied knowledge of her plan of care summary during an interview with the Nursing Home Administrator and the Director of Nursing on April 22, 2026, at 2:15 PM. Social services documentation dated April 22, 2026, at 6:13 PM (following the surveyor's questioning) revealed that the staff met with Resident 119 that afternoon and provided her with her baseline care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide dependent residents with activities of daily living assistance for two of three residents reviewed (Residents 30 and 9).Findings include: Observation of Resident 30 on April 21, 2026, at 2:09 PM revealed several days of stubble (short hair growing back on face). Observation and interview with Resident 30 on April 22, 2026, at 10:59 AM revealed the stubble remained on Resident 30's face and when asked if he would like to be shaved Resident 30 replied sure. Clinical record review for Resident 30 revealed his most recent Quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident needs) dated February 27, 2026, indicated nursing staff assessed Resident 30 as requiring substantial to maximum assistance for personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, washing/drying face and hands). There was no documentation indicating staff were providing shaving assistance to Resident 30. Interview with the Nursing Home Administrator and Director of Nursing on April 24, 2026, at 10:57 AM confirmed the above findings for Resident 30. The Nursing Home Administrator confirmed Resident 30 is unable to shave himself and wished to be shaven. Observation of Resident 9 on April 21, 2026, at 12:45 PM revealed her to have long straight hair that appeared oily (not clean). Clinical record review for Resident 9 revealed a quarterly MDS assessment dated [DATE], and a significant change MDS dated [DATE], that assessed Resident 9 as dependent on the substantial/maximal assistance of staff for showering/bathing. A plan of care developed by the facility on October 9, 2025, to address her deficits with performing activities of daily living, reiterated that she required the assistance of staff for bathing/showering. Resident 9's plan of care did not indicate that she refuses bathing assistance. Review of Resident 9's bathing task history revealed the following established schedule for bathing:February 15, 2025, showers Mondays and Thursdays on first shift (7:00 AM to 3:00 PM)April 8, 2026, showers Tuesdays and Fridays on second shift (3:00 PM to 11:00 PM)Review of Documentation Survey Report (electronic documentation completed by nurse aide staff who assist residents to complete care needs) data dated April 2026 revealed that no evidence that staff provided Resident 9 a shower from April 1 through first shift on April 21, 2026, as follows: April 2, 2026, bed bathApril 6, 2026, bed bathApril 10, 2026, bed bathApril 14, 2026, no data for either a bed bath or showerApril 17, 2026, bathing documented as NA (not applicable) The surveyor reviewed the above concerns regarding Resident 9's bathing care during an interview with the Nursing Home Administrator and the Director of Nursing on April 22, 2026, at 2:15 PM. 483.24(a)(2) ADL Care Provided for Dependent ResidentsPreviously cited deficiency 4/4/25 and 3/9/26 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	04/24/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to implement the highest practicable care regarding central venous catheters for one of 23 residents reviewed (Resident 119).Findings include: The facility policies entitled, Peripherally Inserted Central Line Catheter (PICC), Dressing Change for Vascular Access Devices, and Maintaining Patency of Peripheral and Central Vascular Access Devices, last reviewed March 1, 2026, did not include measures the facility would implement in a resident's plan of care that to ensure the highest practicable care for the PICC line use (e.g., emergency kit/procedures, staff competencies, limb restrictions). Interview with the Director of Nursing on April 24, 2026, at 8:15 AM confirmed that the facility had no licensed staff competencies completed related to the use of PICC lines. The interview also confirmed that the facility had no policy related to the implementation and documentation of all care interventions necessary for the use of a PICC line as noted above. Clinical record review for Resident 119 revealed that the facility admitted her on April 18, 2026. Nursing documentation dated April 18, 2026, at 11:28 AM revealed that Resident 119 arrived at the facility for ongoing antibiotic therapy related to her right knee replacement that became infected. admission physician orders dated April 18, 2026, for Resident 119 included the use of the following: PICC line (a long, flexible tube inserted into a vein in the arm that reaches a large central vein near the heart, used for long-term intravenous treatments; the line requires careful care and monitoring for complications including bleeding, infection, and blood clots) to right upper extremityCeftriaxone Sodium (antibiotic) 2 gram intravenously in the afternoon for knee infection Interview with Resident 119 on April 22, 2026, at 10:31 AM revealed that she had an intravenous access site in her right bicep area that staff use to administer intravenous antibiotics daily. Resident 119 stated that she reminds staff not to use her right arm for blood pressure assessments as necessary. Observation of Resident 119's right bicep area on the date and time of the interview confirmed the presence of intravenous tubing. Observation of Resident 119 and her room environment on April 22, 2026, at 10:31 AM revealed no signage or indication that caregivers should restrict the use of her right arm (e.g., for blood pressure assessments or venipuncture). Interview with Employee 1 (registered nurse/unit manager/infection preventionist) on April 22, 2026, at 10:44 AM confirmed that there was no indication in Resident 119's room or on her person (e.g., bracelet) to indicate any limb restrictions for her right arm. Employee 1, then, obtained a laminated sign to post above Resident 119's bed to alert caregivers to restrict use of her right arm. Review of Resident 119's clinical record revealed a new physician's order (following the surveyor's questioning) dated April 22, 2026, at 2:45 PM for staff to implement right arm limb restrictions. Review of the plan of care initiated by the facility on April 20, 2026, to address Resident 119's use of intravenous medication and PICC line revealed no intervention to restrict the use of her right arm until April 22, 2026. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of select facility policy and procedures, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to ensure an environment free from potential accident hazards for one of one resident reviewed regarding smoking (Resident 1). Findings include: Review of the policy entitled Smoking and E-Cigarettes last reviewed on March 9, 2022, indicates that smoking will only be permitted in posted designated areas, and that smoking is prohibited in all other areas. The policy does not indicate where smoking materials should be stored when not in use. Review of Resident 1's smoking agreement dated May 2, 2022, indicated that smoking and lighting material will be kept in a designated area and not in the resident's possession, items will be labeled and clearly identified per resident, and at the end of the smoking period the materials will be collected and returned to their appropriate location. Review of Resident 1's clinical record revealed a Smoking Assessment completed on February 13, 2026, indicating that nursing staff assessed her as being able to continue smoking without incident. The assessment indicated that the facility would be storing her lighter and cigarettes. This Smoking Assessment also noted Resident 1 was informed/educated regarding smoking policy. Interview of Resident 1 on April 23, 2026, at 9:25 AM, revealed that she knows she is to smoke in the designated smoking area outside of the facility. Resident 1 reported she always has her cigarettes and lighter on her and does not return them to the appropriate location as stated in the smoking agreement and assessment. Observation of Resident 1 on April 23, 2026, 10:58 AM, revealed her to be smoking on the concrete next to the red brick pillar, and not in the designated smoking area of the facility. Interview with Resident 1 on April 23, 2026, at 12:00 PM, revealed that her smoking materials, cigarettes and lighter, are in her purse attached to her rolling walker and not at the nursing station. Interview with Nursing Home Administrator and Director of Nursing on April 23, 2026, at 2:10 PM, confirmed the above findings for Resident 1. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement the administration of supplemental oxygen per the physician's order for one of one resident reviewed for oxygen concerns (Resident 120).Findings include: Observation of Resident 120 on April 21, 2026, at 2:04 PM revealed him to be in his room with supplemental oxygen administration via a room concentrator set to two liters per minute. Observation of Resident 120 with Employee 8 (licensed practical nurse) on April 23, 2026, at 10:09 AM revealed that Resident 120 supplemental oxygen room concentrator was set to 1.5 liters per minute. Clinical record review revealed an active physician's order dated April 7, 2026, for staff to administer supplemental oxygen continuously at three liters per minute every shift. Review of Resident 120's plans of care developed by the facility to address Resident 120's care needs revealed no entries related to supplemental oxygen use until April 21, 2026. Interview with Employee 8 on April 23, 2026, at 10:26 AM confirmed active physician orders for Resident 120 instructed staff to maintain supplemental oxygen administration at three liters per minute; there were no physician orders for staff to titrate (lower) the liter flow. Employee 8 stated that she had not obtained Resident 120's vital signs (that would include an assessment of his oxygen saturation, pulse oximetry) as of the date and time of the interview. The surveyor reviewed the above concerns regarding Resident 120's supplemental oxygen use during an interview with the Director of Nursing on April 24, 2026, at 8:15 AM. 483.25(i) Respiratory/tracheostomy Care and SuctioningPreviously cited deficiency 4/4/25 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer, provide education regarding the benefits, risks, and potential side effects, or administer a COVID immunization for two of five residents reviewed for immunizations (Residents 30 and 36).Findings include: The policy entitled Covid-19, last reviewed without changes March 1, 2026, revealed the facility will conduct education, surveillance, and infection control and prevention strategies to reduce the risk of transmission of COVID-19. Due to the constantly changing and fluid nature of the virus, the facilities will monitor, follow, and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), CMS, and the state Department of Health to include identification and isolation Of any suspected cases. The facility will encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Clinical record review for Resident 30 revealed that the facility admitted him on May 19, 2022. Review of Resident 30's immunization history revealed that he did not receive a COVID (a contagious respiratory illness caused by a virus) vaccine since July 23, 2024. Resident 30's clinical record contained no additional information that the facility offered or administered Resident 30 a COVID immunization after July 2024. Clinical record review for Resident 36 revealed that the facility admitted her on July 9, 2021. Review of Resident 36's immunization history revealed that she refused a COVID vaccine on June 30, 2022. Resident 36's clinical record contained no additional information that the facility offered, or provided education regarding the benefits, risks, and potential side effects with the COVID vaccine after June 2022. Interview with Employee 1 (infection preventionist) on April 23, 2026, at 12:51 PM confirmed the above findings for Residents 30 and 36. The surveyor reviewed the above concerns regarding Resident 30 and 36's COVID-19 immunizations during a meeting with the Nursing Home Administrator and Director of Nursing on April 23, 2026, at 2:00 PM. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services