

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner, maintain equipment in a sanitary condition, and prepare food items in accordance with professional standards in the facility's main kitchen and store a resident's tube feed in a safe and sanitary location on one of four nursing units reviewed (North Hall Nursing Unit, Resident 11). Findings include: Initial tour of the facility's main kitchen with Employee 9, Dietary Director, on February 8, 2026, at 9:10 AM revealed the following: A hand-washing sink was starting to detach from the wall. A section of wall behind the dishwasher had flaking paint. A temperature booster box for the dishwasher located on the floor adjacent to the dishwasher was observed to be leaking water from underneath the unit. Employee 9 revealed this unit started leaking recently and a work order (a system used to keep track of maintenance work requests) was placed. A refrigerator contained a pitcher of a brown colored liquid and a yellowish colored liquid. The items were not labeled. A facility placed date on the yellowish colored liquid was unreadable. A lid on a garbage receptacle had an extensive build-up of dried stains and food debris. An unlabeled plastic cup was observed on a small table near the spices. The cup contained a liquid and plastic lid. Employee 9 revealed that it was sanitizer for the kitchen thermometer. Another refrigerator contained a small stainless-steel pan with tin foil. There were no dates or labels on the pan. This refrigerator also contained a container with what Employee 9 identified as diced peppers. There were no labels or dates on the pan. A refrigerator adjacent to the tray line preparation area contained multiple small glasses of liquid drinks that were not labeled or dated. There were multiple unlabeled small plastic containers that contained cooked eggs. Review of a maintenance work order provided by facility staff for the leaking booster box under the dishwasher observed as noted above revealed a creation date of February 8, 2026, at 10:38 AM, after the observation occurred. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:10 PM. Observation of Resident 11's room on February 8, 2026, at 11:03 AM, February 9, 2026, at 12:23 PM, and February 10, 2026, at 10:33 AM revealed there was a box stored directly on the floor of Resident 11's room with six containers of Osmolite (tube feeding formula). Reviewed the above findings with the Nursing Home Administrator and Director of Nursing on February 10, 2026, at 2:40 PM, who confirmed to prevent the potential for contamination, the tube feeding formula should not be stored directly on the floor. 483.60(i)(1)-(2) Food safety requirements Previously cited deficiency 1/24/25 28 Pa. Code 201.14(a) Responsibility of licensee		

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: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 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 interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to maintain a clean and safe environment on three of four nursing units (South, East and West, Residents 2, 8, 9, 29, and 85). Findings include: Observation of Resident 2's room on February 8, 2026, at 11:30 AM and on February 9, 2026, at 12:30 PM revealed the left side bathroom door frame had a chip of wood out of it, a chip of wood out of the bathroom door near the bottom corner, and a scrape down to the wood, horizontally around the middle of the inside of his room door. There was loose dirt behind the door to his room. It was also noted that the floor was dirty from the doorway to the resident's bed with loose dirt and a hazy dull streak indicating where feet had tracked. Observation of Resident 29's room on February 9, 2026, at 12:41 PM revealed loose dirt on the floor with pieces of paper. It was also noted that Resident 29's first and third dresser drawer handles were hanging down on one side. She indicated that they had been that way for a while. Observation of Resident 85's room on February 10, 2026, at 1:30 PM revealed dust and dirt noted to the right as you enter the room. The cove base was noted to be coming off in the corner to the right as you entered her room. The door to her room was marred with chips of wood out near the bottom. The Nursing Home Administrator and the Director of Nursing were made aware of the above noted environmental concerns for Residents 2, 29, and 85 during a meeting on February 11, 2026, at 9:35 AM. Observation of the resident lounge at the end of the East Hall Nursing Unit on February 8, 2026, at 12:31 PM revealed four ceiling lights that had a significant accumulation of debris in the protective covers. Observation of Resident 8's room on February 8, 2026, at 2:45 PM revealed a large brown colored stain on the corner ceiling tile located above the resident's recliner. A concurrent interview with Resident 8 revealed the stain was from a previous leak in the roof. The above information for the resident lounge and Resident 8 were reviewed in a meeting with the Nursing Home Administrator on February 10, 2026, at 10:56 AM. Interview with Resident 9 on February 8, 2026, at 1:13 PM revealed concerns related to a leak in the roof at the corner of his room. The resident stated that the leak initiated about a week prior and was described as a waterfall but had since slowed to a trickle. Concurrent observation revealed that a large commercial sized round yellow garbage bin on a wheeled base was sitting in the corner of Resident 9's room. Further inspection revealed that one of the tiles from the drop ceiling above the garbage bin was removed, exposing a pipe that was dripping into the garbage bin. The garbage bin was noted to be 5 inches from being filled with clear liquid. Two additional resident room sized trash bins were noted to be partially filled with clear liquid to the left of the yellow bin. On the floor to the right of the large garbage bin was a white towel that appeared to have been left on the floor wet, but was now dried and wrinkled, with yellowing edges. Observation on February 9, 2026, at 9:07 AM and again on February 10, 2026, at 10:05 AM revealed the state of the above-mentioned items in Resident 9's room to be unchanged. Resident 9's room environment was discussed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 1/24/25 28 Pa. Code 201.14(a) Responsibility of licensee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policies and procedures, and staff and responsible party interview, it was determined that the facility failed to obtain appropriate documentation for a device used as a physical restraint for one of one resident reviewed for restraint use (Resident 6). Findings include: The policy entitled Physical Restraints, last reviewed without changes September 9, 2025, revealed physical restraints are only used when they are used appropriately to treat a resident's medical symptoms and to promote an optimal level of function for the resident. If an adaptive device is being used an Adaptive Equipment assessment will be completed by a licensed nurse or therapist to determine if the device is limiting the resident's freedom of movement or normal access to one's body. If device is found to be limiting movement, the Restraint Assessment will be completed. The least restrictive device should be used with documentation of all other alternatives tried prior to the implementation of a restraint. An order for the use of restraint will be received from the physician which includes medical symptoms for use, frequency of use, type of restraint, release protocols, and a plan for reduction. Notification to the residents and/or family of the risks of physical restraints and documentation of informed consent/education on use must be obtained anytime there is a restraint applied. The resident's care plan will be updated with the use of a restraint. A restraint review should be completed at least quarterly with updates if applicable. Clinical record review revealed the facility admitted Resident 6 on September 4, 2021, with diagnoses including cerebral palsy. Review of Resident 6's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated December 30, 2025, revealed staff assessed Resident 6 using a trunk restraint daily. Review of previous MDS assessments dated November 2, and August 25, 2025, revealed nursing staff also assessed Resident 6 as utilizing a trunk restraint daily. Review of Resident 6's clinical record revealed a Restraint Use/ assessment dated [DATE], noting staff assessed Resident 6 for the use of a harness and seatbelt for use in her wheelchair. The assessment revealed Resident 6 is at a significant risk of serious or fatal injury if a fall should occur out of chair due to her diagnosis of cerebral palsy, epilepsy, and having an extrapyramidal movement disorder and severe cognitive impairment. The only previous restraint assessment was completed February 26, 2025. Interview with Resident 6's family on February 10, 2026, at 2:20 PM revealed that staff utilize the seat belt/harness restraint when they are feeding Resident 6. Resident 6's family explained when staff feed Resident 6 her wheelchair is in the upright position and her restraint is utilized, and when she is seated in the hallway her wheelchair is tilted/reclined. Further review of Resident 6's clinical record revealed there was no physician order, or plan of care addressing Resident 6's restraint. These findings were reviewed with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:38 PM. Further interview with the Nursing Home Administrator and Director of Nursing on February 11, 2026, at 9:38 AM confirmed there was no documentation of monthly assessments, a physician order, or a plan of care addressing Resident 6's restraint until after surveyor questioning. 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care for one of 19 residents reviewed for advance care planning (Resident 11), and one of three residents reviewed for skin conditions (Residents 3). Findings include: Observation of Resident 3 on February 8, 2026, at 12:48 PM revealed that the skin on his cheeks and forehead was reddened and he had white flaking skin noted to his forehead, cheeks, and eyebrows. Many white flakes were also noted to be around the collar of the resident's shirt. Observation of Resident 3 on February 9, 2026, at 9:19 AM revealed the skin on his cheeks and forehead was reddened and he had white flaking skin noted to his forehead, cheeks, and eyebrows. Clinical record review for Resident 3 revealed a medical progress note dated [DATE], which stated the resident has some dried skin on face. No further documentation could be identified regarding the dry skin. The above information related to Resident 3 was reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. Observation of Resident 11 on February 8, 2026, at 11:03 AM revealed he was in bed sleeping, with a tube feeding hung at his bedside. Interview with Resident 11 on February 9, 2026, at 12:23 PM revealed he does not want his tube feeding. Clinical record review revealed the facility admitted Resident 11 on [DATE]. Review of Resident 11's physician orders revealed a current order for enteral feedings, initiated [DATE]. Review of a POLST (Physician Orders for Life Sustaining Treatment, a medical order that communicates a patient's wishes for end of life) dated [DATE], signed by Resident 11 indicated that he did not want artificial hydration or nutrition. Resident 11's POLST was updated [DATE], noting he continues to not want hydration and artificial nutrition by tube. Further review of Resident 11's clinical record revealed a physician assistant progress note dated [DATE], noting a discussion with Resident 11 regarding advance care planning and Resident 11 requested a do not resuscitate order (cardiopulmonary resuscitation (CPR) would not be attempted if the resident stopped breathing) with limited additional interventions, including no antibiotics, hydration, or artificial nutrition by tube. Reviewed the above findings for Resident 11 with the Nursing Home Administrator and Director of Nursing on February 10, 2026, at 2:33 PM. Further discussion with the Nursing Home Administrator and Director of Nursing on February 11, 2026, at 9:38 AM, revealed that the facility spoke to Resident 11 and he wants to discuss discontinuing his tube feeds with his physician. The facility failed to provide the highest practical care to Resident 11 related to his advance care planning. 483.25 Quality of Care Previously cited deficiency [DATE] and [DATE] 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on employee personnel record review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 1, 2, and 3). Findings include: The facility noted the following hire dates for three employees reviewed for performance evaluations (EPR, employee performance review): Employee 1's hire date of September 21, 2022. Employee 2's hire date of May 1, 2019. Employee 3's hire date of September 29, 2021. A request to review the annual performance evaluations revealed no documented evidence that the facility completed performance evaluations for Employees 1, 2, and 3 (nurse aides) at least once every 12 months. Employees 1 and 3's last performance evaluations were December 5, 2024. Employee 2's last performance evaluation was November 20, 2024. Interview with the Nursing Home Administrator and Director of Nursing on February 10, 2026, at 2:23 PM confirmed that performance evaluations were not completed annually on the three employees requested. 28 Pa. Code 201.19 (2) Personnel policies and procedures		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and resident and staff interview, it was determined that the facility failed to secure medications on two of four nursing units (West and North, Resident 11). Findings include: Observations of Resident 11's room on the North nursing unit on February 8, 2026, at 11:20 AM, February 9, 2026, at 9:45 AM, and February 10, 2026, at 10:52 AM, revealed a container of Normal Saline Solution (used to restore or maintain fluid volume, especially when oral intake is not possible), on the resident's bedside stand with an expiration date of February 19, 2022. The above findings for Resident 11 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on February 10, 2026, at 2:30 PM. Observation of the North nursing unit medication cart on February 11, 2026, at 8:15 AM revealed the cart was in use by Employee 8, licensed practical nurse, during a medication pass. Observation of this medication cart revealed the following: There were several unsecured and unidentified medications found in the bottom of two of the drawers that included: five round white-colored pills; a blue/green colored capsule; a green oblong tablet; a white oblong tablet; a round, brown-colored pill; a round, yellow-colored pill; and half an oblong, white-colored tablet. The above findings were reviewed in a meeting with the Nursing Home Administrator on February 11, 2026, at 9:47 AM. Observation on the [NAME] nursing unit on February 8, 2026, at 12:17 PM revealed the [NAME] nursing unit medication cart parked along a wall in the hallway near the nursing station. Residents were observed ambulating in the hallway by the cart. The cart was unattended and unlocked. The surveyor was able to open the cart and access resident medications within the cart. Concurrent interview with Employee 12, licensed practical nurse, confirmed that this medication cart should have been locked before it was left unattended. Observation on the North nursing unit on February 9, 2026, at 3:00 PM revealed the North nursing unit treatment cart parked along a wall near the nursing station as residents were ambulating in the hallway by the cart. The cart was unattended and unlocked. The surveyor was able to open the cart and access resident medicated treatments and medical supplies. Concurrent interview with Employee 8, licensed practical nurse, confirmed that this treatment cart should have been locked before it was left unattended. The above medication storage and security concerns related to the [NAME] nursing unit medication cart, and the North nursing unit treatment cart were reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. 483.45(g)(h)(1)(2) Label/store Drugs and Biologicals Previously cited deficiency 2/16/24 and 1/24/25 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical record review, review of select facility policies and procedures, and resident and staff interview, it was determined that the facility failed to determine a resident's capability to self-administer their medications for one of 19 residents reviewed (Resident 22). Findings include: The facility policy entitled Medication Self Administration, last reviewed without changes September 9, 2025, revealed the resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. Residents who have been deemed appropriate to self-administer medications independently or with supervision/cueing or after set-up, shall have a physician order to do so. The screen will be re-evaluated quarterly and more frequently as clinically indicated. Medications to be self-administered shall be secure in a locked area in the resident's room or stored in the medication cart for provision to the resident to self-administer. Any significant change in the resident's condition will be promptly reported to the Director of Nursing and/or the resident's attending physician with rescreening for self-administration performed to ensure self-administration of medications is still safe. The resident will be provided with a medication administration record to document the self-administration medications. Proper documentation of self-administration will be reviewed and used as a factor to determine continued self-administration at the next review. The self-administration of medications will be care planned with interventions specific to the individual resident. Clinical record review revealed the facility admitted Resident 22 on January 5, 2026. Review of Resident 22's physician orders revealed the following orders: Dialysis Monday, Wednesday, Friday, with a chair time of 11:00 AM, transported by Step van, and dietary to provide lunch, initiated on January 9, 2026. Renvela (medication used to control high phosphorus levels in adults with chronic kidney disease on dialysis) tablet 800 milligrams (mg), three tablets by mouth three times a day, initiated on January 8, 2026. Interview with Resident 22 on February 8, 2026, at 1:47 PM revealed that she goes out of the facility to dialysis three days a week. Resident 22 stated that she takes her lunch and a large white pill to take with her to dialysis. Review of Resident 22's clinical record on February 8, 2026, revealed no evidence of a Self-Administration Screen, or physician order for Resident 22 to self-administer her Renvela. The facility did not complete a Self-Administration Screen until February 9, 2026, after the surveyor's questioning. The facility did not get an order for Resident 22 to self-administer her Renvela medication on dialysis days until February 9, 2026, after the surveyor's questioning. The above findings for Resident 22 were reviewed during a meeting with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:30 PM. The Nursing Home Administrator confirmed that Resident 22 was not assessed to self-administer her medication until after surveyor questioning. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and staff interview, it was determined that the facility failed to ensure residents' rights to secure confidential personal and medical information in the facility's main lobby, one of four nursing units (North Hall Nursing Unit) and three of 19 residents reviewed (Residents 11, 53, and 60). Findings include: Observation of hallway in the area located in front of Nurse Station 1 at the end of the North Hall Nursing Unit on February 8, 2026, at 12:10 PM revealed a facility binder on the wall titled Pennsylvania Department of Health Survey Book. The binder contained the results of recent surveys of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Observation of the facility's main lobby area on February 8, 2026, at 1:38 PM revealed a facility binder on the wall titled Pennsylvania Department of Health Survey Book. The binder contained the results of recent surveys of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Review of the contents of these binders revealed that the facility placed the full health survey letters and complaint deficiency letters (letters sent to administration after a survey) into the binder. Further review of the binders revealed a deficiency letter and associated Statement of Deficiencies (Form CMS-2567) for a survey on February 16, 2024. The letter noted the full name and associated specific resident identifiers for Residents 11 and 60. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on February 8, 2026, at 1:40 PM. Observation of a medication pass with Employee 8, licensed practical nurse, on the North Hall Nursing Unit on February 11, 2026, at 8:12 AM revealed a medication cart with a plastic garbage receptacle attached to the side. The garbage receptacle contained an empty medication card with a prescription label attached containing Resident 53's name, and dosing instructions for mycophenolate mofetil oral capsules (a medication used to prevent organ rejection after transplant and treatment of autoimmune diseases). An interview with Employee 8 on February 11, 2026, at 8:12 AM revealed that the medication card with the attached identifying information for Resident 53 should not be thrown away in the regular trash. Employee 8 informed that the resident identifiers on the medication card should be torn off and placed in the shredder bin located near the nurse station. The above information for Resident 53 was reviewed in a meeting on February 11, 2026, at 9:47 AM. The facility failed to ensure the right to privacy of their personal and medical information for Residents 11, 53, and 60. 28 Pa. Code: 201.18(e)(1) Management		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 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 notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for three of six residents reviewed for hospitalizations (Residents 3, 6, and 36). Findings include: Review of Resident 3's clinical record revealed they were transferred to the hospital on November 5, 2025, December 13, 2025, and January 30, 2026. There was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 3's transfer to the hospital on November 5, 2025, December 13, 2025, or January 30, 2026. Review of Resident 6's clinical record revealed that the facility transferred her to the hospital from [DATE] to 26, 2025. There was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 6's transfer to the hospital on December 23, 2025. Review of Resident 36's clinical record revealed they were transferred to the hospital on November 6, 2025, and November 22, 2025. There was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 36's transfer to the hospital on November 6, 2025, or November 22, 2025. Interview with the Nursing Home Administrator and Director of Nursing on February 11, 2026, at 10:04 AM confirmed the above findings for Resident 3, 6, and 36. The facility failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for Residents 3, 6, and 36. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 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 a resident's status for 3 of 19 residents reviewed (Residents 29, 70, and 22). Findings include: Clinical record review for Resident 29 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 9, 2026, that indicated section C of the assessment (cognitive patterns) was documented with dashes indicating Resident 29 was not assessed for cognitive status. Further clinical record review for Resident 29 revealed a quarterly MDS assessment dated [DATE], that indicated she was assessed as having no cognitive impairment with a BIMS (Brief Interview for Mental Status) of 15, (a score of 13-15 is intact cognition). Interview with Resident 29 on February 9, 2026, at 11:45 AM revealed her to be alert and oriented with no noticeable cognitive deficits. Interview with the Nursing Home Administrator on February 9, 2026, at 2:00 PM confirmed that Resident 29 was cognitively intact. She indicated that the social service director who is responsible for completing section C of the MDS went out on leave and they did not realize Resident 29's section C assessment was not done until the assessment reference date had passed, so they had to code Resident 29's cognitive status as not assessed. The facility failed to accurately assess Resident 29's cognitive pattern for the MDS assessment as noted above. Clinical record review for Resident 70 revealed a quarterly MDS dated [DATE], that indicated Section C of the assessment (cognitive patterns) was documented in all areas as not assessed. Further clinical record review for Resident 70 revealed a Discharge Return Anticipated MDS assessment dated [DATE], that indicated multiple areas of Section C documented by staff as not assessed. Further clinical record review for Resident 70 revealed a quarterly MDS assessment dated [DATE], that indicated the resident was assessed as having a BIMS of 13. Interview with Resident 70 on February 9, 2026, at 10:35 AM revealed the resident to be alert and with no noticeable cognitive deficits and answered questions appropriately. The above information for Resident 70 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:10 PM. The Nursing Home Administrator revealed that the staff member responsible for completing section C of the MDS went on leave and the facility did not realize Resident 70's Section C assessment was not completed until the assessment reference date had passed, so the facility had to code Resident 70's cognitive status as not assessed. The facility failed to accurately assess Resident 70's cognitive pattern for the MDS assessments as noted above. Clinical record review for Resident 22 revealed an admission MDS dated [DATE], that indicated section C of the assessment (cognitive patterns) was documented with dashes indicating Resident 22 was not assessed for cognitive status. Interview with Resident 22 on February 8, 2026, at 11:45 AM revealed her to be alert and oriented with no noticeable cognitive deficits. The above findings for Resident 22 were reviewed with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:28 PM. The facility failed to accurately assess Resident 22's cognitive pattern for the MDS assessments as noted above. 483.20(g), F641, Accuracy of Assessments Previously cited 1/24/25 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff and resident interview, it was determined that the facility failed to implement a comprehensive, person-centered care plan regarding a diagnosis for PTSD (Post-Traumatic Stress Disorder, a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress) for one of 19 residents reviewed (Resident 9). Findings Include: During an interview with Resident 9 on February 8, 2026, at 1:38 PM, the resident stated he was diagnosed with PTSD related to a history of childhood sexual trauma. Clinical record review for Resident 9 revealed that the resident was diagnosed with PTSD on March 8, 2025. Review of Resident 9's current comprehensive plan of care (a summary of a resident's personal health, nursing, and psychological well-being needs and how they can be met) included two stated goals; I will remain comfortable and safe in my environment, and I will not have episodes of crisis. There were two listed interventions including, Discuss feelings of anger with resident, and I want to stay in contact with my friends/family. The care plan did not describe what individualized interventions would assist Resident 9 to remain comfortable within their environment. The care plan did not describe what an episode of crisis looks like for the resident or how to address these episodes with the resident to achieve these stated goals. The above information regarding the care plan was reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. 28 Pa. Code 211.10. (a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 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 observation, clinical record review, and resident family and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of four residents reviewed (Resident 11). Findings include: Observation of Resident 11 on February 8, 2026, at 12:58 PM revealed he was sleeping in bed and his hair appeared long (shoulder length) and disheveled. Interview with Resident 11 on February 9, 2026, at 1:52 PM revealed that he wished to have his hair cut. Concurrent interview with Resident 11 on February 10, 2026, at 10:15 AM revealed Resident 11 again stated a desire to have his hair cut, indicating he was not sure why it was taking so long. The findings for Resident 11 were reviewed with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:30 PM. They were unable to provide an explanation as to why Resident 11 has not received a haircut for an extended period. Review of social service documentation dated February 9, 2026, at 6:00 PM revealed social worker asked Resident 11 if he would like a haircut, and Resident 11 voiced yes. There was no evidence that the facility offered, or Resident 11 refused to have his hair cut. 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited deficiency 1/24/25 28 Pa. Code 211.12(d)(1)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on clinical record review, observation, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide appropriate treatment and services for a resident who is fed by enteral (feeding tube) means to prevent potential complications for one of one resident reviewed for tube feeding concerns (Resident 36). Findings include: Review of facility policy titled Policy & Procedure Tube Feeding: Continuous Tube Feeding last reviewed on September 9, 2025, states under step 7 of the procedure to elevate the head of the bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated. Observation of Resident 36 on February 8, 2026, at 12:20 PM revealed the presence of a feeding tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications; also known as a PEG tube) connected to a feeding pump (a mechanical device used to pump fluids and a specialized liquid nutrition source referred to as feed, through a G-tube at a pre-set rate). A concurrent observation of the feeding pump revealed that the feeding pump was actively administering feed through the residents feeding tube while Resident 36 was in bed, with the bed laying in a flat position. Observation of Resident 36 on February 9, 2026, at 9:10 AM revealed that the feeding pump was actively administering feed through the residents feeding tube while Resident 36 was in bed, with the bed laying in a flat position. Clinical record review revealed that Resident 36 had an active physician's order dated March 3, 2024, to elevate the residents HOB (head of bed) while the tube feed is running and for one hour after the feed is completed every shift for preventing aspiration (food or liquid entering the airway/lungs). The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:25 PM. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing service		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 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 clinical record review, observation, and staff interview, it was determined that the facility failed to store respiratory care equipment in a sanitary manner on one of four nursing units (South, Resident 33) and provide respiratory care consistent with professional standards of practice for one of two residents reviewed for respiratory concerns (Resident 4). Findings include: Observation of Resident 33's bedside table on February 8, 2026, at 12:24 PM revealed a nebulizer machine (a compressor device that converts liquid medication into a fine mist, allowing for easier inhalation into the lungs) with nebulizer tubing (a removable, flexible hose that connects the nebulizer machine to the liquid medication cup, allowing air to flow through and convert liquid medication into a mist for inhalation) and a nebulizer mask with a medicine cup (a breathing mask worn over the nose and mouth connected to the medicine cup, which ensures that the aerosolized medicine is adequately inhaled) on the table. The mask appeared to be coated in a slightly opaque white colored film, and the medicine cup had dried droplets of liquid noted to the inside of the medicine cup. Observation of Resident 33's bedside table on February 9, 2026, at 12:10 PM again revealed a nebulizer machine with attached nebulizer tubing and a nebulizer mask and medicine cup on the table. The mask continued to appear to be coated in a slightly opaque white colored film, but the medicine cup was noted with droplets of liquid to the inside of the medicine cup. Concurrent observation of the bedside table revealed food debris/crumbs, a dried drop of a red liquid, and a spoon that appeared to have been previously used. The above findings regarding the condition of Resident 33's nebulizer machine was discussed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. Clinical record review revealed the facility admitted Resident 4 on January 21, 2022, with diagnosis of chronic obstructive pulmonary disease (COPD). A diagnosis of chronic respiratory failure with hypoxia (insufficient oxygen supply) was added April 25, 2025. A physician's order initiated on July 1, 2024, instructed staff to administer Resident 4 continuous oxygen at two liters per minute (LPM) by nasal cannula (medical tubing that delivers supplemental oxygen directly to the nose). Observation of Resident 4 on February 8, 2026, at 10:52 AM and 2:51 PM revealed she was seated in her wheelchair with her oxygen being administered at three LPM. Observation of Resident 4 on February 10, 2026, at 9:49 AM revealed she was seated in her wheelchair with her oxygen being administered at one LPM. The above information for Resident 4 was reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:30 PM. 483.25(i) Respiratory Care Previously cited 1/24/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with wound vacs for four of four employees reviewed (Employees 4, 5, 6, and 7). Findings include: Clinical record review revealed the facility admitted Resident 3 on November 20, 2025. A physician order dated January 13, 2026, revealed nursing staff are to apply a wound vac (a therapy that uses a device to decrease air pressure on a wound) to Resident 3's sacral area wound using black foam and setting to 125 mmhg (millimeters of mercury). A request for nursing staff competencies for Resident 3's wound vac revealed the facility was unable to provide any competencies related to wound vacs for Employees 4 and 5 (licensed practical nurses) and Employees 6 and 7 (registered nurses). The findings were reviewed with the Nursing Home Administrator and Director of Nursing on February 11, 2026, at 9:44 AM. They confirmed the facility could provide no documentation that ensured Employees 4, 5, 6, and 7 had specific competencies and skill sets to care for Resident 3's needs listed above. 483.35(a)(3)(4)(d) Competent Nursing Staff Previously cited deficiency 1/24/25 28 Pa. Code 201.20 (a) Staff Development		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review and staff interview, it was determined that the facility failed to obtain and provide medications for one of 19 residents reviewed (Resident 20). Findings include: Clinical record review for Resident 20 revealed that the facility admitted her on June 16, 2017. Further clinical record review revealed that she had diagnoses of bipolar disorder (a mental health disorder characterized by intense mood swings, ranging from extreme highs to deep lows), psychotic disorder with hallucinations (a loss of contact with reality, characterized by hearing voices, seeing things, or feeling sensations that are not there), restlessness and agitation, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, uncontrollable worry), and vascular dementia with agitation (triggered by brain damage from reduced blood flow to the brain causing cognitive decline with behaviors of increased motor activity, restlessness, irritability, and aggression). Review of Resident 20's medication administration record (MAR) for December 2025, revealed that Resident 20 was to receive one milliliter of Lorazepam (a medication used to treat anxiety) 0.5 milligrams (mg) per milliliter (ml) gel topically two times a day. Resident 20's MAR for December 2025, revealed that the medication was not administered on December 25-26, 2025, at 8:00 AM or 8:00 PM, and it was not administered on December 27, 2025, at 8:00 AM due to the medication not being available. Clinical record review for Resident 20 revealed a progress note dated December 25, 2025, at 8:27 AM that indicated Lorazepam 0.5 mg/ml Gel was not available and they were awaiting pharmacy delivery of the medication. A progress note dated December 25, 2025, at 9:45 PM revealed that the facility was waiting on delivery of Resident 20's Lorazepam 0.5 mg/ml Gel. A progress note dated December 26, 2025, at 8:08 AM revealed that Resident 20's Lorazepam 0.5 mg/ml Gel was unavailable. The writer indicated that the medication was ordered last week and pharmacy would be called. A progress noted dated December 26, 2025, at 1:16 PM indicated that the writer called the pharmacy but was unable to get an answer as to whether the medication had been shipped. A progress note dated December 27, 2025, at 4:18 AM revealed that the pharmacy was called and the representative stated that the medication was not reordered but they would fill the medication now and send it on the next pharmacy run between 9:00 AM-12:00 PM. A pharmacy order status report dated February 10, 2026, provided by the facility revealed that the Resident 20's Lorazepam 0.5/ml Gel was reordered on December 15, 2025, but the pharmacy only sent enough for eight doses. The medication was not reordered again until December 27, 2025, after Resident 20 missed 5 doses. An email dated February 10, 2026, at 12:19 PM, provided by the pharmacy to the facility indicated that Resident 20's Lorazepam refill request was received by them on December 27, 2025, at 4:00 AM (after hours). The email indicated that the pharmacy filled and shipped the medication on December 27, 2025. An interview with the Director of Nursing and Nursing Home Administrator on February 11, 2026, at 9:30 AM confirmed the noted information related to the unavailability of Resident 20's Lorazepam 0.5 mg/ml gel. The facility failed to ensure Resident 20 received her physician ordered medications as noted above. 483.45 Pharmacy ServicesPreviously cited June 4, 2025 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent on one of four nursing units (North Nursing Unit; Residents 75 and 94). Findings include: The facility's medication error rate was 11.54 percent based on 26 medication opportunities with three medication errors. Review of Resident 75's current physician orders revealed an order dated September 24, 2025, for Potassium Chloride (potassium supplement) ER (extended release) oral tablet 20 mEq (milliequivalent); give 1 tablet by mouth two times a day, dissolve in small amount of fluid for slurry. Observation of Resident 75's medication administration on February 8, 2026, at 8:37 AM revealed that Employee 10, licensed practical nurse, crushed the Potassium Chloride ER tablet and placed it in pudding with additional crushed medications to administer to Resident 75. Employee 10 did not prepare the Potassium Chloride ER as ordered. Drugs.com (an online comprehensive source of drug information) states do not chew, break, or crush the medication. Review of Resident 75's current physician orders revealed an order dated March 25, 2025, for Calcium 600 plus D plus Minerals (a calcium and vitamin supplement) oral tablet chewable 600-400 mg (milligrams) - unit (international units) (calcium carbonate-vitamin D with minerals); give 1 tablet by mouth one time a day for supplement. Observation of Resident 75's medication administration on February 10, 2026, at 8:35 AM revealed that Employee 8, licensed practical nurse, prepared the medications prior to administration. This preparation included one Calcium 600 plus Vit D3 (a house stock medication containing Calcium 600 mg and Vitamin D 5 mcg (micrograms). Five mcg is the equivalent of 200 units of Vitamin D which was not the concentration of the medication ordered for the resident. Employee 8 then proceeded to administer the medication to Resident 75. Resident 75's medication administration concerns were reviewed with the Nursing Home Administrator and the Director of Nursing on February 10, 2026, at 2:45 PM. Review of Resident 94's current physician orders revealed an order dated August 28, 2023, for Calcium 600 plus D plus minerals oral tablet 600-400 milligrams-unit (calcium carbonate - vitamin D with minerals); give one tablet by mouth two times a day for calcium deficiency. Observation of Resident 94's medication administration pass on February 11, 2026, at 8:10 AM revealed that Employee 8, licensed practical nurse, prepared the medications prior to administration. This preparation included one Calcium 600 plus Vit D3 (a house stock medication containing Calcium 600 mg and Vitamin D 5 mcg). The medication only contained 200 units of Vitamin D and not the 400 units ordered. Employee 8 then proceeded to administer the medication to Resident 94. An interview with Employee 8 on February 11, 2026, at 11:00 AM confirmed that the Vitamin D dose in the house stock medication did not match the dose specified in the physician order for Resident 94. The Nursing Home Administrator and Director of Nursing were notified of the findings for Resident 94 on February 11, 2026, at 11:03 AM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on a review of select facility policies and procedures, observation, and staff and resident interviews, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of eight residents reviewed for infection control (Resident 22). Findings include: The facility policy entitled Isolation Precautions, last reviewed without changes September 9, 2025, revealed contact precautions will be implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment. Residents should be placed in a private room when available. Prior to entering the isolation room, the following steps are required: perform hand hygiene and apply gloves and gown prior to entering room, while providing direct resident care, wear gloves and wash hands after coming into contact with infectious material, remove gloves and perform hand hygiene before leaving room. Clinical record review revealed the facility admitted Resident 22 on January 5, 2026. Interview with Resident 22 on February 8, 2026, at 12:35 PM revealed that she came to the facility from the hospital due to Clostridioides difficile (c-diff, a bacterium that causes diarrhea and inflammation of the colon). Review of Resident 22's physician's orders revealed an order for contact precautions for c-diff initiated January 5, 2026. Observation of Resident 22 on February 8, 2026, at 1:20 PM revealed Employee 11 (laundry aide) entered Resident 22's room to put Resident 22's laundry away. Employee 11 wore gloves but did not don (put on) a gown. Observation of Resident 22 on February 8, 2026, at 1:25 PM revealed Employee 10 (licensed practical nurse) entered Resident 22's room and administered Resident 22 her medications. Employee 10 wore gloves but did not don a gown. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 3:07 PM, who confirmed staff are to wear gloves and gowns when entering a resident's room on contact precautions. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 1/24/25 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of employee personnel and education records and staff interviews, it was determined that the facility failed to ensure that each nurse aide received 12 hours of in-service training annually for one of three nurse aides reviewed (Employee 1). Findings include: Review of Employee 1's, nurse aide, personnel record revealed that the facility hired her on September 21, 2022. The surveyor requested training records for Employee 1 during an interview with the Nursing Home Administrator and the Director of Nursing on February 9, 2026, at 2:38 PM. Review of training records provided by the facility for Employee 1 on February 10, 2026, revealed that Employee 1 completed only 3.35 hours of in-service education in the last year. Interview with the Director of Nursing and the Nursing Home Administrator on February 11, 2026, at 9:44 AM confirmed the above findings for Employee 1, and were unable to provide any further documentation indicating Employee 1 received 12 hours of in-service training annually. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0756 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of select facility policy and procedure and staff interview, it was determined that the facility failed to develop policies and procedures for the monthly medication regimen reviews that included time frames for the different steps in the process. Findings include: A review of the facility policy titled, Medication Regimen Review, last reviewed September 9, 2025, revealed a purpose that the consultant pharmacist shall review the medication regimen of each resident at least monthly. Further review of the policy revealed the following (in part): the consultant pharmacist will communicate the findings and recommendations in writing on a medication regimen review report; the consultant pharmacist will contact the Director of Nursing or designees when irregularities are noted that require immediate action to protect the resident and prevent the occurrence of an adverse drug event; any irregularities will be communicated to the physician utilizing a written recommendation and report for consideration; information on the medication regimen reviews and written recommendations will be reviewed by the Director of Nursing or designee and the Director of Nursing or designee will send the medication regimen review to the appropriate provider for follow-up; providers will review the medication regimen review from the pharmacist, follow-up as applicable, and return the medication regimen review form to the Director of Nursing or designee. The policy did not contain specific time frames for the pharmacist to communicate findings and recommendations in writing on the medication regimen review report, the time frame to contact the Director of Nursing or designee when irregularities are noted that require immediate action to protect the resident and prevent the occurrence of an adverse drug event, the time frame for the pharmacist to communicate to the physician, the time frame for physician response, or the time frame for the Director of Nursing or designee to review the medication regimen report. The facility failed to develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process. The above information was reviewed with the Nursing Home Administrator on February 10, 2026, at 10:05 AM. 28 Pa. Code 201.18 (d) Management		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook South		STREET ADDRESS, CITY, STATE, ZIP CODE 101 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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage. Findings include: Observation of the facility's main dumpsters located outside near the rear of the building with Employee 9, Dietary Director, on February 8, 2026, at 9:40 AM revealed the following: A trash dumpster had bagged garbage overflowing and a dumpster lid partially ajar due to the overflowing trash. Another dumpster lid was also open with bagged trash visible. There was debris including multiple paper towels observed discarded on the ground A recycling dumpster was overflowing with cardboard. There were three empty boxes for oatmeal creme pies on the ground adjacent to dumpster. A large construction dumpster had paper trash visible near the perimeter of the dumpster. At least two medical gloves were observed discarded on the ground adjacent to dumpster. There were wood shards, an empty beverage can, and paper products discarded adjacent to the dumpster. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 9, 2026, at 2:10 PM. 28 Pa. Code 201.14(a) Responsibility of licensee		