STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395397	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook on Second Ave	200 Second Avenue Kingston, PA 18704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, employee personnel records, clinical records, facility-provided investigative documentation, and staff interviews, it was determined the facility failed to implement its established abuse prevention and response policies following an allegation of abuse for one resident (Resident 1) out of 9 residents reviewed and failed to follow required employee screening procedures for one of three employees reviewed (Employee 1) Findings include:A review of the facility's Abuse and Neglect Prevention Policy defined serious bodily injury to include sexual acts involving a resident who is unable to consent or understand the nature of the act. The policy directed that in the event of suspected maltreatment (abuse, neglect, or exploitation), the resident must be assessed for injuries and trauma. The policy also directed staff to preserve evidence by not bathing or cleaning the resident, not washing or discarding clothing or linens, and not destroying documentation. The policy further directed that if maltreatment may involve a crime, the facility must immediately notify the police and report the allegation to the State agency no later than two hours after the allegation is made.A review of the facility's Abuse and Neglect Prevention Policy defined serious bodily injury as sexual intercourse with a resident by force or when the resident is incapacitated (unable to resist or protect themselves due to physical or mental condition). The policy further defined serious bodily injury to include sexual intercourse with a resident who is unable to refuse participation or who lacks the ability to understand the nature of the sexual act. The policy directed that when maltreatment (abuse, neglect, or exploitation) is suspected, the resident must be assessed for changes in physical appearance, skin injuries, bruising, and signs of trauma (physical or emotional injury caused by an event). The policy instructed staff to follow applicable state and local laws related to preserving evidence (protecting items or information that may be used in an investigation). The policy further directed staff not to interfere with potential evidence by washing clothing or bed linens, destroying records, bathing or cleaning the resident before the resident is examined, or failing to transfer the resident to the emergency department for medical examination, including a rape kit (a medical and forensic examination used to evaluate injuries and collect physical evidence after a suspected sexual assault). The policy directed that if suspected maltreatment may involve a crime, the facility must immediately notify the police. The policy further directed that the facility must report the allegation to the State agency immediately, but no later than two hours after the allegation is made. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with a diagnosis of dementia (a condition involving decline in memory, reasoning, and the ability to understand or make decisions). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 19, 2025, revealed that Resident 1 was severely impaired with a BIMS score of 03 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment). A clinical record review revealed Resident 2 was admitted on [DATE], with diagnoses including depression (a mood disorder that affects how a person feels, thinks, and acts). A review of a quarterly MDS dated [DATE], revealed Resident 2 was cognitively intact with a BIMS score of 14, (a score of 13-15 indicates intact cognition). A review of Resident 2's care plan dated December 29, 2025, revealed the resident was identified as being at risk for behavioral and emotional episodes related to mental health symptoms. The care plan indicated Resident 2 experienced visual hallucinations (seeing people, objects, or things that are not actually present), which were described as distressing to the resident and others. The care plan also indicated Resident 2 experienced auditory hallucinations (hearing voices or sounds that are not actually present), which were also distressing to the resident and others.The care plan further documented that Resident 2 made verbal complaints (spoken statements) of feeling down, depressed, and hopeless, as well as feelings of anxiety (persistent worry or nervousness). The care plan also documented complaints of feeling nervous and having an inability to obtain restful sleep (difficulty sleeping through the night), which impaired the resident's quality of life (overall comfort, well-being, and ability to function day to day). The care plan also identified that Resident 2 had the potential for ineffective coping (difficulty managing stress or emotional responses in a healthy way) related to a traumatic event (a highly distressing or disturbing experience), specifically as a survivor of a domestic incident (violence or abuse that occurred in a personal relationship). A review of a progress note dated January 19, 2026, at 1:00 PM revealed Resident 1's roommate (Resident 2) reported to staff that Resident 1 was possibly the victim of sexual assault by a male caregiver (Employee 1, Nurse Aide). The note documented Resident 2 reported Employee 1 put on gloves and told Resident 1, you're going to have the time of your life. The note further documented that a body audit (a visual skin and body check for injuries) was completed, and no visible injuries were observed. A review of facility investigative documentation revealed Resident 2 reported an allegation of possible sexual assault to the Activity Director at approximately 11:15 AM on January 19, 2026. At that time, Resident 2 stated Employee 1 sexually assaulted Resident 1 at approximately 5:00 AM. A review of a witness statement from Resident 2 revealed Resident 2 reported hearing noises from Resident 1 and Employee 1. The statement documented Resident 2 heard Employee 1 tell Resident 1, we are going to get it right this time, I am not going to hurt you, I promise I will be gentle. The statement further documented Resident 2 reported she did not observe any sexual contact but heard Resident 1 say to Employee 1, you're nothing but a freak. Resident 2 stated she believed Employee 1 raped Resident 1 based on the manner in which Employee 1 spoke to Resident 1. The statement further documented Resident 2 asked Resident 1 if Employee 1 had ever made her feel uncomfortable, and Resident 1 responded no .A review of a witness statement dated January 19, 2026, revealed Social Services asked Resident 1 whether any staff member had touched her inappropriately, whether anyone had entered her room at night and touched her private areas, whether she had pain on her body, and whether she had pain, burning, or redness in her private areas. Resident 1 answered no to each question. A review of a witness statement from Employee 3 (Licensed Practical Nurse) dated January 19, 2026, revealed Resident 1 was observed wandering the facility throughout the night and frequently at the nurse's station. Employee 3 documented Resident 1 appeared to be in no distress.A review of a witness statement from Employee 1 revealed Resident 1 had a bowel movement while wandering in a hallway. Employee 1 documented that he took Resident 1 into a bathroom to clean and change her. Employee 1 documented Resident 1 was resistant, stated she did not need to use the bathroom, and yelled at him. Employee 1 documented Resident 1 was resistant to sitting on the toilet while (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being cleaned. Employee 1 documented he cleaned the resident, dressed her in clean clothing, transferred her back to her wheelchair, and escorted her back into the hallway. Employee 1 documented Resident 2 was upset about being awakened during this care. A review of a witness statement from Employee 4 (Nurse Aide) dated January 19, 2026, revealed she observed Resident 1 in a bathroom on the opposite side of the building with bowel movement on her clothing and wheelchair. Employee 4 documented Employee 1 offered to clean Resident 1 so Employee 4 could complete another assigned task. Employee 4 documented she observed Resident 1 multiple times after Employee 1 cleaned her and that Resident 1 showed no signs of distress.An interview with the Activity Director on January 21, 2026, at 12:35 PM revealed Resident 2 approached her in the hallway and stated she believed Resident 1 was possibly raped. The Activity Director stated she immediately escorted Resident 2 to the Nursing Home Administrator (NHA) to report the allegation. An interview with the NHA on January 21, 2026, at 1:00 PM revealed Resident 2 was brought to her office at approximately 11:00 AM on January 19, 2026, and an allegation of possible rape was reported. The NHA stated she began an investigation at that time. When asked why Resident 1 was not transferred to the emergency department for medical evaluation, including a rape kit (a forensic medical examination used to collect and preserve evidence after a sexual assault), until approximately ten hours later, the NHA stated she offered emergency room evaluation to the resident's responsible party at approximately 1:00 PM and the family declined, despite facility policy requiring preservation of evidence and hospital evaluation. The NHA stated it was not until a later conversation at approximately 7:00 PM that the family agreed to send the resident to the hospital. An interview with Resident 1's responsible party on January 21, 2026, at 1:30 PM revealed she was informed of a possible rape when she arrived at the facility at approximately 1:00 PM on January 19, 2026. The responsible party stated she was not offered the option to send Resident 1 to the emergency department during her visit and was repeatedly told by staff that the incident did not occur. An interview with Resident 2 on January 21, 2026, at 9:45 AM revealed that on the morning of January 19, 2026, at approximately 5:00 AM, she observed Employee 1 enter the shared room. She stated she heard Employee 1 tell Resident 1 it would be okay and that he would be gentle. Resident 2 stated Resident 1 did not want to go into the bathroom and was calling Employee 1 names. Resident 2 stated she heard Employee 1 instruct Resident 1 to stand and hold onto grab bars, then to sit on the toilet, then to stand again and hold onto the bars. Resident 2 stated Employee 1 exited the bathroom, retrieved a brief and clothing from Resident 1's closet, and returned to the bathroom. Resident 2 was questioned about whether she heard any sounds of distress, moaning, or statements such as stop from Resident 1. Resident 2 stated she did not hear Resident 1 express distress. Resident 2 stated she asked Resident 1 if Employee 1 had ever made her feel uncomfortable, and Resident 1 responded no. When asked why she believed Resident 1 was assaulted, Resident 2 stated Employee 1 called Resident 1 baby. Resident 2 further stated that whenever Employee 1 entered the room, Resident 1 would raise her hands to her face. Resident 2 stated she believed Resident 1 was raped based on Employee 1's manner of speaking and Resident 1's reactions when Employee 1 was present. An interview attempt with Employee 1 on January 21, 2026, was unsuccessful. A second attempt on January 22, 2026, resulted in Employee 1 stating that due to the escalation of the situation, he would not provide a statement. An interview with Employee 2 (Nurse Aide) on January 21, 2026, at 12:47 PM revealed she showered Resident 1 on the morning of January 21, 2026, at approximately 10:15 AM after again finding Resident 1 with bowel movement on her clothing and wheelchair. Employee 2 stated she was unaware of any sexual abuse allegation prior to bathing the resident. Employee 2 stated she cleaned the resident's private area to remove fecal matter. An interview with a police department clerk on January 21, 2026, at 11:30 AM (continued on next page)

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