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	06/06/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by three residents out of 29 residents sampled (Residents 2, 3, and 5) and four out of five residents interviewed during a resident group interview (Residents 4, 61, 77, and 112). Findings include: During a resident council meeting on June 4, 2025, at 10:00 AM, Residents 4, 61, 77, and 112 voiced concerns about the timeliness of staff response to activated call bell lights. Resident 112 stated he rang his call bell for assistance the night before but did not receive help for over one hour. He needed assistance with toileting. He reported that he has waited at least 30 minutes anytime he utilized the call bell. Resident 4 stated that he frequently waited over an hour for staff to answer his call bell. He stated that staff often enter his room, turn off his call bell light, and leave without providing care. He said they tell him they will be right back, but they never come back He recalled an incident where he soiled his incontinence brief and waited two hours for care after his call bell was silenced. He expressed that delays are more frequent during the evening shift. Resident 77 stated that she frequently waited one to two hours at night for staff assistance after she had activated her call bell. She expressed frustration that staff enter her room, turn off her call bell light, say they will return, but never return or only return after she re-activated the call bell light a second time. Resident 61 stated she rarely used her call bell, but when she did, it typically took over 30 minutes for staff to respond. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe) and type 2 diabetes (body has trouble controlling blood sugar and using it for energy). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 30, 2025, revealed that Resident 5 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates intact cognitive responses). During an interview on June 3, 2025, at 11:20 AM, the resident stated she waited up to an hour for care during the day shift and was concerned about the delays. A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that included below the knee amputation of the right lower extremity (leg), blindness of the left eye, and low vision of the right eye. A review of an annual MDS dated [DATE], revealed that Resident 3 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates intact cognition). During an interview on June 3, 2025, at 11:30 AM Resident 3, reported excessive wait times for staff assistance. He stated staff often responded to his call bell, said they needed to find another staff member (due to his two-person assist needs), and then did not return. He also reported difficulty locating the call bell when seated in his wheelchair due to his vision impairment. At the time of the interview, observation revealed the call bell was on the floor near the head of the bed and out of his reach. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes and chronic obstructive pulmonary disease. A review of a quarterly MDS dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15. During an interview on June 3, 2025, at 11:55 AM, Resident 2 indicated she experiences long wait times for care. She indicated she often waits 30 minutes or longer before receiving assistance after activating her call bell. During an interview on June 5, 2025, at approximately 10:30 AM, the Nursing Home Administrator (NHA) acknowledged that all residents should be treated with dignity and respect and receive care in a timely manner that promotes quality of life. The NHA was unable to explain why multiple residents reported consistent delays in staff response to call bells. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(4) Nursing services.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to conduct a care plan conference and failed to ensure that the resident was invited to participate in the care planning process for one of 29 residents reviewed (Resident 112). Findings include: A clinical record review revealed Resident 112 was admitted to the facility on [DATE], with diagnosis to include a below the knee amputation of the left lower extremity (leg), and end stage renal disease (final, permanent stage of chronic kidney disease, where the kidneys can no longer function on their own). A review of the quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 12, 2025, revealed that Resident 112 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognitively intact). During an interview on June 3, 2025, at 12:05 PM, Resident 112 stated he has not been invited to participate in the care planning process for development of his comprehensive person-centered care plan or attend any care plan meetings. A further review of the clinical record revealed no documented evidence that a care plan conference had been conducted for Resident 112 or that the resident had been invited to participate in the development or review of his comprehensive care plan. During an interview with the Director of Nursing (DON) and the Admission's Director on June 5, 2025, at 11:20 AM, both confirmed there was no documentation to show that a care plan conference had been held for Resident 112 or that the resident had been invited to participate in the care planning process. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12(d)(3) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the discharge status of one resident out of 29 sampled (Resident 180). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section A0310F: Entry/Discharge Reporting indicates to review the medical record for entry/type of discharge (return anticipated versus return not anticipated). A review of Resident 180's clinical record revealed the resident was admitted to the facility on [DATE], and discharged to the hospital on May 18, 2025. Further review of the resident's payor status indicated the resident was private pay and did not elect to continue private payment for his room while hospitalized , a key indicator that the return was not anticipated. However, the Discharge Return Anticipated MDS assessment dated [DATE], documented in Section A0310F Entry/Discharge Reporting the resident was discharged with return anticipated, contrary to the resident's payor status and discharge planning information. During an interview conducted on June 5, 2025, at 11:00 AM, Employee 4 (Registered Nurse Assessment Coordinator) acknowledged that the MDS assessment for Resident 180 was inaccurate and confirmed that Section A0310F should have indicated a discharge with return not anticipated based on the circumstances of the resident's hospitalization and decision not to pay privately to hold the bed. 28 Pa. Code 211.12(d)(3) Nursing services.

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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** 48277 Based on a review of clinical records and staff interview, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to thoroughly assess, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice, for one residents out of 29 sampled residents (Resident 3) and failed to provide nursing care consistent with professional standards of practice in accordance with physician orders for one resident out of 29 sampled residents (Resident 93). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient's designated support person A review of the clinical record revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome, right below the knee amputation, and Type 2 diabetes (body has trouble controlling blood sugar and using it for energy). A review of Resident 3's hospital records dated June 21, 2024, documented the resident previously underwent a spinal cord stimulator stage I implantation of lead and generator (refers to the initial trial phase of spinal cord stimulation therapy. It involves temporary placement of leads (electrodes) in the spinal epidural space to evaluate whether electrical stimulation can effectively relieve a patient's chronic pain before permanent implantation) performed on November 26, 2019. A review of Resident 3's Admission assessment dated [DATE], failed to document the presence of the spinal cord stimulator implant. Physician orders for Resident 3 did not reflect the presence of, or any required care or precautions related to, the spinal cord stimulator. Additionally, review of the resident's plan of care, current as of the survey ending June 6, 2025, failed to address the spinal cord stimulator despite identifying multiple comorbidities including chronic pain from phantom limb syndrome and osteoarthritis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on June 5, 2025, at 11:35 AM, confirmed the facility failed to perform a comprehensive assessment related to the spinal cord stimulator, failed to obtain relevant physician orders, and failed to include the device in the resident's plan of care to meet the resident's medical and treatment needs. A review of the facility policy titled Physician Orders, last reviewed by the facility on May 5, 2025, revealed that it is the policy of the facility to provide guidance to ensure physicians orders are transcribed and implemented in accordance with professional standards. The licensed nurse is required to record the order accurately in the medical record and is required to record the order on the appropriate administration record of the MAR/TAR (Medication Administration Record/Treatment Administration Record). A review of the facility policy titled Administering Medications, last reviewed by the facility on May 5, 2025, revealed that it is the policy of the facility that the individuals administering medications shall sign the residents MAR for the specific time and date the medication was administered, and if it is discovered the person administering the medications has forgotten to sign in the e-Mar, the supervisor or designee shall notify that person to investigate if the medication or treatment has been administered or performed. If the response indicates the medication or treatment was administered, the staff member shall return to the facility to complete appropriate documentation, and a late entry note will be documented indicating the administration of the medication. A review of the clinical record revealed that Resident 93 was admitted to the facility on [DATE], with diagnoses to include epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures, which include uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2025, revealed that Resident 93 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Physician orders dated April 9, 2025, directed the resident receive Levetiracetam 750 mg (an anti-seizure medication used in those with epilepsy, and it is crucial to follow the prescribed dosage and to not stop taking it suddenly, as this can increase seizure frequency) by mouth daily for idiopathic epilepsy. Further review of the clinical record revealed a physician's order dated April 21, 2025, for the night shift to give 9:00 AM meds at 7:00 AM due to Resident 93 having an appointment and leaving at 7:15 AM, and the appointment location was an hour away from the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's progress note dated April 22, 2025, at 7:15 AM, confirmed that the resident was transferred to the appointment accompanied by a Certified Nursing Assistant (CNA). A later progress note at 9:54 AM documented that the facility received a call from the CNA reporting the resident became unresponsive during the appointment and was transported to the emergency department. Resident 93's representative was present at the appointment and aware of the incident. A 2:22 PM note on the same day indicated the resident was diagnosed with a possible seizure and treated with appropriate medications as per telephone contact by the emergency department. A clinical review of an outside report from an emergency room , dated April 22, 2025, for Resident 93 revealed that she came in after an unresponsive episode at her appointment, and there were concerns that she had experienced a focal seizure. Resident 93 was then treated with the appropriate medications and became she became responsive after. Review of the facility's Medication Administration Record (MAR) for April 2025 showed that Levetiracetam 750 mg was documented as administered at 10:21 AM by Employee 5, LPN. However, the resident was not present in the facility at that time. There was no documentation of a late entry or clinical progress note to justify this late recording. The facility's internal investigative documentation dated April 24, 2025, stated that the nurse administered the medication prior to the resident's departure but failed to document it due to a shift change. The investigation noted the nurse was re-educated but did not provide statements from the resident, her representative (who was present at the appointment), or the accompanying CNA. The facility also failed to explain why the night shift did not administer the medication as ordered. During an interview on June 3, 2025, at 11:25 AM, Resident 93 stated she had not received her seizure medication prior to leaving for her appointment despite requesting it several times and voiced concern over leaving the facility without taking her prescribed anti-seizure medication. Resident 93 stated that they did not give her a reason as to why her medications could not be given prior to leaving and stated she questioned why she was leaving the facility prior to taking her seizure medication, with no answer She stated that she experienced a seizure during the appointment and required emergency treatment as a result. During an interview with the DON on June 7, 2025, at approximately 9:00 AM, the DON acknowledged the facility failed to document the medication administration at the time of actual administration and failed to follow established policy for documenting late entries. The DON confirmed that nursing staff failed to comply with physician orders and standards of nursing documentation. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(i)(iii)(iv) Medical records.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053 Based on a review of clinical records, facility investigative documentation, and staff interviews, it was determined the facility failed to provide adequate supervision and implement a planned intervention to prevent intrusive wandering by a cognitively impaired resident (Resident 103) which resulted in a resident-to-resident altercation for two of 29 sampled residents (Residents 91 and 103). Findings include: A clinical record review revealed that Resident 91 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and hypertension (blood pressure that is higher than normal). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 4, 2025, revealed that Resident 91 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of Resident 91's comprehensive care plan, initiated on July 5, 2023, indicated the resident had the potential to be verbally aggressive and/or loud with outbursts toward others, using vulgar or foul language, secondary to ineffective coping skills and poor impulse control. An intervention initiated on September 24, 2024, directed the placement of a stop sign at Resident 91's doorway to deter wandering residents from entering. A clinical record review for Resident 103 revealed an admitted [DATE], with diagnoses including dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A quarterly MDS of Resident 103, dated April 23, 2025, revealed the resident was severely cognitively impaired. A quarterly MDS dated [DATE], documented that Resident 103 was severely cognitively impaired. The comprehensive care plan, initiated on November 5, 2024, identified the resident as an elopement risk and a wanderer due to dementia. A nurse progress note dated April 29, 2025, at 5:00 PM documented that a Certified Nurse Aide (CNA) observed Resident 91 backing his wheelchair into Resident 103 and then striking him with his arm. At that time, the planned intervention of a stop sign on Resident 91's door had not been implemented. The stop sign was only applied after the altercation had occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent nurse progress note dated April 29, 2025, at 6:26 PM revealed that Resident 103 was redirected out of Resident 91's room after a verbal outburst from Resident 91, Get out of my room. Shortly afterward, Resident 103 again passed by Resident 91, at which time Resident 91 attempted to roll backward toward Resident 103 and then physically struck the resident's arm. The incident was reported to the nurse supervisor, and a full assessment of Resident 103 found no injury or pain. Notifications were made to the resident representative, local police, and the Department of Aging. A review of a facility investigation report dated April 30, 2025, revealed that Resident 103 was attempting to enter Resident 91's room, and Resident 91 was sitting in his doorway and was yelling, Get out of my room, and Resident 103 self-propelled past Resident 91, and a CNA witnessed Resident 91 attempt to roll backwards into Resident 103 and was not successful, so Resident 91 shoved and hit Resident 103's right arm with his elbow. A body audit was completed, and no injuries were noted on Resident 103. Immediate interventions included separation of Resident 91 and Resident 103, and a stop sign was placed in front of Resident 91's doorway to deter Resident 103 from re-entering his room. Further review of this investigation revealed the conclusion was Resident 91 became physically aggressive towards Resident 103 due to the resident's wandering behaviors. During an interview conducted on June 7, 2025, at 9:00 AM, Resident 91 confirmed there had been no stop sign at his door at the time of the incident on April 29, 2025. Observations conducted on June 7, 2025, at 9:00 AM revealed the absence of a stop sign at Resident 91's doorway, contrary to the intervention outlined in his care plan. This was confirmed with Employee 1, Registered Nurse. In an interview conducted on June 7, 2025, at approximately 12:30 PM, the Director of Nursing confirmed the facility's failure to implement the planned intervention of a stop sign at Resident 91's doorway, acknowledging this may have contributed to Resident 103's entry into the room and the resulting physical altercation. The Director of Nursing further confirmed that it is the facility's responsibility to implement appropriate safety measures to prevent resident-to-resident altercations and potential abuse. 28 Pa. Code 201.18 (b)(1)(e)(1) Management. 28 Pa. Code 211.12 (d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on observation, staff interview, and review of facility policy and clinical record, the facility failed to ensure respiratory equipment was maintained in a sanitary and functional condition for one resident (Resident 40) out of 29 sampled residents. Findings include: A review of facility policy entitled Oxygen Administration and Storage last reviewed on May 5,2025, revealed a nebulizer mouthpiece (a piece of medical equipment that a person with asthma or other respiratory conditions use to administer medication directly and quickly to the lungs) and tubing should be labeled with the date and changed weekly. A review of Resident 40's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD a disease that restricts airflow to the lungs and causes breathing problems). A review of the Resident 40's clinical record revealed a physician's order dated May 5,2025, for Ipratropium 0. 5mg- Albuterol Sulfate Inhalation solution 3 mg (2.5mg base)/3ml nebulization solution one inhalation orally via nebulizer every six hours as needed for shortness of breath. On June 3, 2025, at approximately 1:55 PM, an observation of Resident 40's room revealed a nebulizer machine located on the bedside table. Attached to the machine was a nebulizer mouthpiece and tubing, visibly labeled with a piece of tape marked March 9. During an interview conducted on June 3, 2025, at 2:00 PM, Employee 2 nurse aide confirmed that the tubing was labeled March 9 and acknowledged that it had not been changed since that date. In a subsequent interview on June 4, 2025, at approximately 9:10 AM, the Director of Nursing (DON) confirmed that, in accordance with facility policy, nebulizer tubing and mouthpieces should be changed weekly. The DON acknowledged that the tubing for Resident 40 had not been replaced in accordance with that policy and confirmed the facility's failure to maintain the resident's respiratory equipment. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on clinical record review, payor source data, resident and staff interview, it was determined the facility failed to ensure timely and necessary dental services for one resident who is a Medicaid recipient (Resident 110) out of 29 residents reviewed. Findings included: Review of the clinical record indicated Resident 110 was admitted to the facility on [DATE], with diagnoses to include unspecified dementia (the loss of cognitive functioning that affects a person's ability to perform everyday activities). Review of a Quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated May 5, 2025, revealed Resident 110 was cognitively impaired with a BIMS score of 7 (Brief Interview for Mental Status, which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 0-7 equates to being severely cognitively impaired). The resident's care plan, initiated on February 10, 2025, identified a potential for oral/dental health problems related to having her own teeth. Interventions included: coordinating arrangements for dental care and transportation as needed or as ordered, and monitoring and documenting any signs or symptoms of oral/dental issues, including missing, loose, or broken teeth. A document labeled MDS Section L Oral Status, dated February 15, 2025, and the Admission Nursing Evaluation dated March 7, 2025, both indicated the resident had her own natural teeth with no dental concerns documented. However, review of the Inventory Sheet of Personal Effects dated February 7, 2025, recorded that the resident had both upper and lower dentures upon admission to the facility. An interview with Resident 110 on June 3, 2025, at approximately 11:35 AM, revealed she had been admitted to the facility with both upper and lower dentures. During the interview, Resident 110 stated her lower denture went missing a few weeks after admission. She could not recall the exact date but stated she informed her husband. She was unsure whether her husband reported this to the facility. Resident 110 stated she had adapted by eating a soft, bite-sized diet. Observation of Resident 110 on June 3, 2025, at approximately 11:35 AM confirmed the resident was wearing an upper denture only, the lower denture was not present. Further review of the document labeled Documentation Survey Report v2 [DATE] indicated that Resident 110 required maximum assistance or was totally dependent on staff to perform her oral care. (continued on next page)

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	06/06/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on June 4, 2025, at approximately 11:00 AM with the Director of Nursing (DON) confirmed the facility failed to identify the resident's lower denture was missing. The DON acknowledged that the inaccurate documentation at admission, failing to recognize the presence of dentures, contributed to the oversight. The DON also confirmed that, following surveyor inquiries, the resident was subsequently scheduled for a dental appointment to replace the missing lower denture. The DON affirmed that it is the facility's responsibility to ensure residents receive the required dental services. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to properly store resident personal care equipment on one of five nursing units (A wing) and failed to store a urinary catheter drainage bag in a manner to limit the potential for infection for one of three sampled residents (Resident 29). Findings include: A review of the facility Infection Control Program Policy last reviewed May 5, 2025, indicated the infection control program exists to assure a safe, sanitary, and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. An observation on June 3, 2025, at 11:58 AM in the bathroom of resident room A 05 revealed a grey bedpan on the floor under the sink, wedged between the garbage can and the wall. The bedpan was not enclosed in a plastic bag and was in direct contact with the floor, wall, and garbage can. A pink wash basin was also observed on the floor in the corner of the bathroom, similarly, unbagged and in direct contact with the floor and wall. Two urinals containing a small amount of yellow liquid were hanging on the grab bar. The urinals were not labeled with a resident name to indicate resident ownership. A second observation of the same bathroom on June 4, 2025, at 2:09 PM revealed the same grey bedpan unbagged and, on the floor, and two unlabeled urinals containing a small amount of yellow liquid still on the grab bar. An additional observation on June 3, 2025, at 12:15 PM of the bathroom in resident room A 09 revealed a grey bedpan on the floor under the sink with a dry washcloth draped over the side of the bedpan. The bedpan was unbagged and in direct contact with the floor. Further observation revealed four wash basins (3 pink and 1 grey) stacked on top of the toilet tank. The basins were not labeled with a resident name or bed number to identify which basin belonged to each resident. There was a bag of unlabeled supplied inside the top basin. An interview conducted on June 5, 2025, at 11:30 AM with the Director of Nursing confirmed that facility procedure requires bedpans and basins to be cleaned after use, bagged, and stored on the bottom shelf of each resident's nightstand. The Director acknowledged that these items should not be stored on the floor or on top of toilet tanks and confirmed the observed practices did not align with facility protocol. A clinical record review revealed Resident 29 was admitted to the facility on [DATE], with diagnoses which include spastic quadriplegic cerebral palsy (brain damage that affects both sides of the brain leading to muscle stiffness and difficulty controlling movement in all four limbs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated April 14, 2025, indicated a suprapubic catheter (18 French/30 cc balloon) to be maintained on a closed drainage system for neuromuscular dysfunction, with monitoring every shift. A physician order dated April 14, 2025, noted an order for a Suprapubic catheter (a type of urinary catheter that is inserted directly into the bladder through a small incision in the lower abdomen, rather than through the urethra) 18 French (catheter's outer diameter)/30 cc balloon (balloon's capacity for holding fluid) to closed drainage system for a diagnosis of neuromuscular dysfunction (disease which affects the motor and sensory nerves that connect the brain and spinal cord to the rest of the body) to be maintained with monitoring the catheter/dignity drainage bag every shift. An observation on June 3, 2025, at 1:50 PM revealed Resident 29's catheter drainage bag, though covered for privacy, was resting directly on the floor. An interview at the time with Employee 3 (Registered Nurse) confirmed the observation and stated that catheter drainage bags are required to be positioned to avoid contact with the floor. An interview on June 5, 2025, at 1:00 PM with the facility's Infection Preventionist confirmed that infection control protocols require catheter drainage bags to be positioned so that they do not touch the floor, to reduce the risk of environmental contamination and infection transmission. The facility failed to ensure personal care equipment and urinary drainage systems were stored and maintained according to infection prevention best practices. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa code 211.12 (d)(1)(5) Nursing services.