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	05/08/2026

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 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 observations and resident and staff interviews, it was determined the facility failed to provide and maintain a clean, comfortable, and homelike environment for residents on two of three nursing units.Findings include: Observation of Station B on May 5, 2026, at 11:38 AM revealed the floor surface in resident room D2, Bed A, was sticky to the touch. Observation of Station B on May 5, 2026, at 11:40 AM revealed the floor surface in resident room D5, Bed B, was sticky to the touch. Observation of Station A on May 5, 2026, at 8:30 AM revealed the floor surface in resident room B5, Bed B, was sticky to the touch. A review of Resident 108's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 10, 2026, revealed that Resident 108 was 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 through 15 indicates cognition is intact). During an interview conducted on May 6, 2026, at 1:30 PM, Resident 108 expressed concerns regarding the cleanliness of the bathroom shared with another resident. Resident 108 stated feces was frequently left on the floor and on the toilet rim by the roommate. Resident 108 also expressed concern regarding the cleanliness of the shower room. Observation of Resident 108's bathroom at this time revealed that the floor surrounding the toilet was stained with a brown colored substance. The rim of the toilet bowl was visibly soiled. The bar surrounding the toilet was worn and discolored. The flooring surrounding the base of the toilet was heavily worn and unsealed. The wall vent located behind the toilet contained a thick accumulation of dust. Observation of the shower room located on A Hall of Station A Nursing Unit on May 6, 2026, at 1:45 PM revealed the shower stall next to the tub area was visibly soiled. The bottom two rows of wall grout were missing grout material and contained a buildup of a black-colored substance. Hair accumulation was present in the drain. The grout on the shower floor was visibly worn and discolored. The ceiling vent located in the center of the shower room contained a thick accumulation of dust. Observation of the shower room on the B Hall of Station A Nursing Unit on May 8, 2026, at 11:20 AM revealed the wall and floor grout in shower stall next to the toilet area was visibly soiled with a black colored substance. The surface of the toilet seat on the toilet in the shower room was worn with a two inch area of paint which was peeled from the surface of the toilet seat. Observation of the shower room located on C Hall of Station B Nursing Unit on May 8, 2026, at 11:35 AM revealed the ceiling vent near the tub area contained a thick accumulation of dust. A floor tile measuring two inches by one inch was chipped near the drain in the middle shower stall. The floor grout in the middle shower stall was visibly soiled with a black-colored substance. The above findings were reviewed with the Nursing Home Administrator on May 8, 2026, at 12:00 PM. 28 Pa Code 201.18(e)(1)(2.1) Management. 28 Pa. Code 201.29 (a) Resident rights.

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:	(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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, select facility policy review, and staff interview, it was determined the facility failed to consistently ensure the provision of respiratory care and supplemental oxygen in accordance with physician orders and facility policy for three residents out of 28 residents reviewed. (Residents 3, 4, and 128).Findings include: Review of the facility's policy titled Oxygen Administration and Storage last reviewed by the facility on April 9, 2026, revealed that oxygen is to be administered at the prescribed amount. During an initial facility tour of the facility on April 5, 2026, at 11:10 AM, and again at 11:35 AM, Resident 3 was observed seated in a wheelchair in the dining room with an oxygen tank attached to the back of the wheelchair. The oxygen tank gauge indicated the tank was empty. This observation was confirmed by Employee 1 (Licensed Practical Nurse). Clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses including chronic cor pulmonal (a form of right-sided heart failure caused by long-term high blood pressure in the lungs stemming from chronic lung disease) and pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). A review of Resident 3's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 6, 2026, revealed that Resident 3 was severely cognitively impaired and was not able to complete the BIMS assessment (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 physician's order dated February 6, 2026, specified oxygen at 2 liters per minute via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen), to be administered continuously. Review of Resident 3's comprehensive care plan, in effect at the time of survey, failed to include the resident's pulmonary diagnoses, physician orders for continuous oxygen therapy, interventions related to oxygen administration and monitoring, or staff responsibilities for ensuring oxygen equipment was functioning and available for use as ordered. During an interview on April 7, 2026, at 2:26 PM, the Director of Nursing (DON) stated the facility was unable to provide documentation identifying the frequency of monitoring oxygen tanks. The DON acknowledged the facility failed to ensure Resident 3 received oxygen therapy as ordered. Clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnosis of recent brain surgery and a tracheostomy (a surgical opening in the neck used to place a tube in the throat as an alternate airway). A review of Resident 4's admission MDS dated [DATE], revealed that Resident 4 was cognitively intact with a BIMS score of 14 (a score of 13 through 15 indicates intact cognition). Review of May 2026 physician orders revealed Resident 4 was to receive 28 percent oxygen through a tracheostomy humidification system. The physician order specified the system required oxygen to flow at 4 liters per minute from an external oxygen source to maintain delivery of 28 percent oxygen to the tracheostomy site. Room air contains approximately 21 percent oxygen. Observation of Resident 4's oxygen delivery system on May 5, 2026, at 11:30 AM, and again on May 6, 2026, at 2:30 PM, revealed the oxygen delivery system was set to deliver 35 percent oxygen with oxygen flowing at 3 liters per minute. Observation of the equipment revealed the system in use could not deliver oxygen concentrations lower than 35 percent. Therefore, the physician-ordered oxygen concentration of 28 percent could not be administered using the equipment provided by the facility. Clinical record review revealed that Resident 128 was admitted to the facility on [DATE], with diagnosis of respiratory failure and a tracheostomy (a surgical opening in the neck used to place a tube in the throat as an alternate airway). A review of Resident 128's admission MDS dated [DATE], revealed that Resident 128 was severely cognitively impaired and was not able to complete the BIMS assessment. Review of May 2026 physician orders revealed Resident 128 was to receive 28 percent to 30 percent oxygen through a tracheostomy humidification system. The physician order specified the system required (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen to flow at 6 liters per minute from an external oxygen source to maintain delivery of 28 percent to 30 percent oxygen to the tracheostomy site. Observation of Resident 128's oxygen delivery system on May 5, 2026, at 11:30 AM, and again on May 6, 2026, at 2:30 PM, revealed the oxygen delivery system was set to deliver 40 percent oxygen with oxygen flowing at 7 liters per minute. Observation of the equipment revealed the system in use could not deliver oxygen concentrations lower than 35 percent. Therefore, the physician-ordered oxygen concentration of 28 percent to 30 percent could not be administered using the equipment provided by the facility. During an interview on May 7, 2026, at 10:30 AM, the Nursing Home Administrator confirmed the oxygen delivery systems for Residents 4 and 128 were not set according to physician orders at the time of the survey observations. The Nursing Home Administrator stated the oxygen settings were corrected after the surveyor identified the concerns and notified facility staff. 28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, review of facility planned menus, select facility policy review, and resident and staff interviews, it was determined the facility failed to honor resident food preferences and ensure residents received meal items and condiments as identified on meal tray tickets, to the extent possible, for 2 of 28 residents reviewed for food services (Residents 10 and 55), and residents participating in a Resident Council group interview (Residents 5, 112, 46, 88, 51, 13, 10, 83, 8, 12, 120, 108, and 92).Findings include: Review of the facility policy titled Resident Food and Meal Preferences, last reviewed by the facility on April 9, 2026, revealed the facility will make reasonable efforts to provide each resident with a nourishing, palatable, well-balanced diet that meets nutritional and special dietary needs while considering resident preferences and input from residents and resident groups. During an interview conducted on April 5, 2026, at 12:12 PM, Resident 55 stated she does not always receive the food items identified on her meal tray ticket or foods she requested. Resident 55 stated she did not receive yogurt, prune juice, or creamers with breakfast that morning. Review of Resident 55's lunch meal tray ticket on April 5, 2026, at 12:35 PM revealed the resident was to receive sugar substitute packets and creamers. Observation of the lunch meal tray revealed the sugar substitute packets and creamers were not provided. Review of Resident 55's breakfast meal tray ticket on April 7, 2026, at 9:00 AM revealed the resident was to receive two cream cheese packets with a toasted bagel. Observation of the breakfast meal tray revealed no cream cheese packets were provided. During an interview conducted on April 7, 2026, at 9:05 AM, the Food Services Director confirmed cream cheese was unavailable in the kitchen despite being listed on Resident 55's meal tray ticket. Review of Resident 10's lunch meal tray ticket on April 5, 2026, at 12:27 PM revealed the resident was to receive gravy. Observation of the lunch meal tray revealed gravy was not provided. During an interview at the time of observation, Resident 10 stated the kitchen frequently forgets to provide ordered items or condiments on meal trays. During a Resident Council group interview conducted on April 6, 2026, at 10:00 AM, Residents 5, 112, 46, 88, 51, 13, 10, 83, 8, 12, 120, 108, and 92 reported meal trays frequently arrived without ordered food items, beverages, or condiments. Residents stated they often had to wait for nursing staff to obtain missing items from the kitchen, causing meals and beverages to become cold before they could eat or drink them. During an interview conducted on April 7, 2026, at 1:35 PM, the Nursing Home Administrator confirmed residents' meal tray tickets should have been followed to ensure residents received food items and condiments according to their identified needs and preferences. 28 Pa. Code 211.6 (a) Dietary Services. 28 Pa. Code 211.10 (c) Resident Care Policies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff interview, it was determined the facility failed to develop and implement a comprehensive person-centered care plan to address aggressive behavior interventions and the care, monitoring, and maintenance needs associated with a central line for one of 28 residents reviewed (Resident 58).Findings include: A review of the policy titled Care Plans, Baseline, and Comprehensive, last reviewed by the facility on April 9, 2026, revealed it is the policy of the facility to ensure that each resident receives care individualized to the resident and that goals and approaches for care are communicated to all parties, including caregivers, the resident, and the resident's representative. The interdisciplinary team will develop an individualized, comprehensive care plan for each resident based on their medical condition, medical history, assessments from different members of the interdisciplinary team, lifestyle, and current resident goals. Clinical record review revealed Resident 58 was admitted to the facility on [DATE], with diagnoses that included 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 diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of sugar in the blood and urine). A review of facility-provided investigative documentation dated February 2, 2026, revealed Resident 58 was involved in a resident-to-resident altercation with their roommate, Resident 40. The documentation revealed Resident 58 admitted to hitting the roommate following an argument regarding the window curtain being closed. The investigative documentation further revealed the facility identified interventions that included redirecting the resident to discuss their dog and redirecting the resident to the lounge/dayroom area to look out the windows. Review of Resident 58's comprehensive care plan, initiated April 15, 2025, revealed the facility failed to develop care plan interventions addressing the resident's aggressive behavior history, including identified interventions for redirection following the resident-to-resident altercation. A review of a physician's order dated April 16, 2026, documented a central line to the right chest (a thin, flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream) 18 French single lumen catheter (a catheter size and single internal channel used to administer fluids or medications). The physician's order directed staff to change the dressing every Thursday evening shift and as needed, maintain an emergency kit at bedside containing gloves, hemostats (a medical instrument used to clamp blood vessels), tape, abdominal pads, and a dressing change kit, and flush the line every shift with 10 milliliters of sodium chloride (a sterile saltwater solution used to maintain the line and prevent blockage) before and after medication administration. Observation of Resident 58 on May 5, 2026, at 11:00 AM revealed a central line present in the resident's right upper chest. Review of Resident 58's comprehensive care plan revealed the facility failed to develop care plan interventions addressing the resident's central line, including monitoring of the insertion site, dressing changes, flushing requirements, infection prevention measures, and ordered maintenance interventions associated with the device. An interview was conducted with the Director of Nursing on May 7, 2026, at 11:30 AM. The above findings were reviewed regarding the facility's failure to develop and implement a comprehensive person-centered care plan to address Resident 58's aggressive behavior interventions and central line care needs. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy review, and staff interviews, it was determined the facility failed to develop and implement an individualized, person-centered plan to provide trauma-informed care for one of 28 residents reviewed (Resident 5) with a diagnosis of Post-Traumatic Stress Disorder (PTSD). Findings include: A review of the facility policy titled Trauma-Informed Care, last reviewed by the facility on April 9, 2026, revealed it is the policy of the facility to ensure that residents who are trauma (deeply distressing or disturbing experience)survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Residents will be screened and assessed upon admission in order to identify any history of trauma and/or post-traumatic stress disorder (PTSD). The interdisciplinary team will ensure that an individualized resident-centered care plan is developed for the resident that has experienced a traumatic event. A review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). A review of Resident 5's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 4, 2026, revealed that Resident 5 was cognitively intact with a BIMS score of 14 (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 through 15 indicates cognition is intact). The MDS further revealed the resident was assessed as yes to having a PTSD diagnosis. A review of Resident 5's current comprehensive care plan, in effect at the time of review on May 5, 2026, failed to identify the resident's PTSD diagnosis, trauma-related symptoms, known triggers, resident preferences, or individualized interventions to minimize emotional distress and prevent re-traumatization. Review of the clinical record failed to reveal evidence the interdisciplinary team developed or implemented resident-specific approaches to provide trauma-informed care, despite the resident's documented diagnosis of PTSD. The facility failed to develop and implement an individualized person-centered plan to address this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Nursing Home Administrator and Director of Nursing on May 6, at 1:00 PM, confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounted for the resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.10 (a)(c) Resident care policies.28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interview, and incident investigation, it was determined that the facility failed to maintain a fully functional call light system for one semi-private room, affecting two of 28 sampled residents (Residents 74 and 127).Findings include: Clinical record review revealed Resident 74 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (a chronic condition affecting blood sugar regulation) and kidney failure (loss of kidney function). A review of Resident 74's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 21, 2026, revealed that Resident 74 was 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 cognition). In addition, it was also noted that the resident had severely impaired vision. An interview conducted with Resident 74 on May 5, 2026, at 10:00 AM revealed the visual call light notification located outside the resident room did not illuminate when the call system was activated so staff could quickly identify that he or his roommate needed assistance from outside of the room. Resident 74 stated the malfunction existed since the time of admission and staff were aware the system was not functioning properly. The resident wanted a different room where the call light system was functioning properly but was not given another choice at the time of admission. Resident 74 indicated due to visual impairment he periodically required staff assistance and stated staff were unable to readily identify when assistance was needed unless staff were physically present at the nurses' station to observe the main call light board. Resident 74 stated he at times experienced delayed staff response and had to go into the hallway and verbally call for assistance and had recently done so because his roommate (Resident 127) had fallen attempting to get back into bed. Observation on May 5, 2026, revealed activation of the call light system for Resident 74's room did not illuminate the visual notification light located outside the resident room. Resident 127 was admitted to the facility on [DATE], with a diagnosis of diabetes and chronic kidney disease. A BIMS assessment score of 15 dated April 29, 2026 indicated the resident was cognitively intact. An interview with Resident 127 on May 5, 2026, at 10:30 AM revealed the resident was aware the visual call light notification located outside the resident room did not illuminate when the call light system was activated and therefore did not alert staff that assistance was needed in the room. Resident 127 stated the malfunction had existed since the time of admission. Resident 127 stated that on May 4, 2026, at approximately 2:00 PM, he was sitting in his wheelchair and wanted assistance returning to bed. The resident stated he pushed his call light button; however, no staff responded. Resident 127 indicated that after waiting for assistance, he attempted to transfer himself from the wheelchair back into bed without staff assistance and subsequently slid from the wheelchair to the floor. Review of facility-provided investigative documentation dated May 4, 2026, at 2:05 PM confirmed Resident 127 was found on the floor after attempting to transfer from the wheelchair into bed without staff assistance. Observation of Residents 74 and 127's room on May 5, 2026, revealed no alternative method was implemented to allow residents to summon staff assistance in place of the malfunctioning visual call light notification system. During an interview conducted on May 5, 2026, at 1:00 PM, the Nursing Home Administrator was unable to provide evidence that the facility timely repaired the malfunctioning visual call light notification system or implemented an alternative method for Residents 74 and 127 to effectively summon staff assistance. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0627 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, and resident and staff interviews, it was determined the facility failed to develop and implement discharge planning consistent with a resident's expressed discharge goals and demonstrated self-care abilities for one of 28 residents reviewed (Resident 7).Findings included: A review of in-service documentation provided by the facility, dated December 2, 2025, revealed that discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. Clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease affecting the body's ability to regulate blood sugar levels) and hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of the body resulting from brain damage caused by interrupted blood flow to the brain). A review of Resident 7's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 10, 2026, revealed that Resident 7 was 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 through 15 indicates cognition is intact). A clinical record review revealed that Resident 7 served as their own responsible party. A care plan indicating Resident 7 was a short-term care resident and would return to the community was initiated on February 5, 2026. Interventions implemented to ensure Resident 7 would have a safe transition back to the community included discussing discharge options with the resident and family and having a discharge care conference to be held closer to discharge. A review of documentation titled Notice of Medicare Non-Coverage (NOMNC) dated February 24, 2026, revealed Resident 7 was notified that Medicare, a federal health insurance program, would no longer cover skilled nursing facility services after February 26, 2026. A review of documentation titled Immediate Notification of Medicare Beneficiary Appeal Request dated February 24, 2026, revealed Resident 7 appealed the termination of Medicare coverage for the skilled nursing facility stay. Review of the appeal documentation revealed the appeal was denied and Medicare coverage for skilled nursing facility services ended. A review of a social worker progress note dated March 20, 2026, at 10:30 AM, revealed the resident requested to set up discharge planning as he felt ready to return home. A review of a social services progress note dated March 24, 2026, at 10:53 AM revealed the social worker discussed discharge planning with Resident 7 and the resident's daughter. The note revealed Resident 7 requested discharge to home. The resident's daughter stated she did not believe the resident was ready for discharge at that time. The note further revealed the resident already possessed a wheelchair and cane at home. The social worker documented that the resident would require diabetic education prior to discharge due to the resident's history of cerebral infarction. A review of a social services progress note dated April 21, 2026, at 9:52 AM, revealed one identified barrier to discharge included insulin administration and blood glucose monitoring (the process of measuring sugar in the blood) education. The note revealed the social worker planned to obtain a physician order for diabetic teaching. A review of a physician's order dated April 21, 2026, at 2:49 PM, revealed an order for diabetic education each shift with documentation of the education provided. A review of a nurse progress note dated April 23, 2026, at 10:30 AM, revealed Resident 7 demonstrated understanding of diabetic education and was doing well with instruction. A review of the resident's Treatment Administration Record (TAR a clinical record used to document treatments and services provided to residents)) for April 2026 and May 2026 (continued on next page)

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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 0627 Level of Harm - Potential for minimal harm Residents Affected - Many	revealed nursing staff documented diabetic education each shift as ordered by the physician. During an interview on May 5, 2026, at 12:00 PM, Resident 7 indicated that he was frustrated and upset that he was still in the nursing facility and not discharged home as planned. Resident 7 indicated that the facility was not actively working with him on discharge planning. Resident 7 indicated that he was told that once he was educated on insulin (a medication used to manage diabetes that is injected into the skin) administration and on performing self-blood glucose monitoring that he would be able to be discharged from the facility. Resident 7 indicated that he independently performed insulin injections and blood glucose monitoring prior to being admitted and even provided the facility with one of his own insulin pens from home to be used for education. Resident 7 stated he routinely left the faciity on leave of absence (LOA, approved temporary leave away from the facility) during daytime hours without incident.A review of Resident 7's LOA documentation for April 2026 and May 2026 confirmed the resident frequently left the facility independently during daytime hours without documented incident. Review of the clinical record revealed no documented follow-up regarding Resident 7's repeated requests for discharge home, reassessment of discharge readiness, physician notification regarding the resident's demonstrated self-care abilities, or updated discharge planning after April 23, 2026, until it was brought to the attention of the facility on May 5, 2026. Clinical record review revealed no documented determination that discharge to the community was unsafe or not feasible and no documentation identifying who made such a determination. During an interview on May 5, 2026, at 1:35 PM, the Social Services Director confirmed Resident 7, and the resident's family expressed a desire for discharge to home. The Social Services Director stated discharge was pending diabetic education and physician approval but could not explain why discharge planning efforts did not progress after the resident completed diabetic education. Following surveyor inquiry, the facility conducted a care conference for Resident 7 on May 7, 2026, at 11:00 AM, with the resident, social worker, and the resident's daughter to discuss discharge planning. The facility failed to facilitate discharge planning consistent with Resident 7's expressed discharge goals, demonstrated ability to perform diabetic self-care tasks, and repeated requests for discharge to the community. This failure delayed progression of discharge planning for Resident 7 consistent with the resident's expressed goals. During an interview on May 7, 2026, at 1:00 PM, the Nursing Home Administrator and Director of Nursing confirmed there was no documented evidence reflecting reassessment of the resident's discharge readiness or an updated discharge planning process for Resident 7 prior to surveyor inquiry. 28 Pa. Code 201.18 (b)(2) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) Nursing services.

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	05/08/2026

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	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 review of clinical records, facility initiated transfer notices, and staff interview, it was determined the facility failed to provide copies of written notice of facility initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for four out of 28 residents reviewed (Residents 1, 2, 14, and 118).Findings include: A review of the clinical record revealed that Resident 1 was transferred to the hospital on January 16, 2026, and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 2 was transferred to the hospital on February 18, 2026, and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 14 was transferred to the hospital on August 6, 2025, and was readmitted to the facility on [DATE]. Resident 14 was also transferred to the hospital on September 27, 2025, and was readmitted to the facility on [DATE]. Resident 14 was also transferred to the hospital on January 29, 2026, and was readmitted to the facility on [DATE]. Resident 14 was also transferred to the hospital on February 21, 2026, and readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 118 was transferred to the hospital on November 30, 2025, and was readmitted to the facility on [DATE]. Although written notices were provided to the resident and resident representative of the facility-initiated transfer, there was no documented evidence the facility sent copies of written notices of these facility-initiated transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the nursing home administrator on May 8, 2026, at 9:30 AM confirmed there was no documented evidence that copies of facility initiated transfer notices for Residents 1, 2, 14, and 118 were sent to a representative of the Office of the State Long-Term Care Ombudsman. The nursing home administrator also confirmed there was no evidence that copies were sent consistently for resident transfers to a representative of the Office of the State Long-Term Care Ombudsman from May 2025 through April 2026. 28 Pa. Code 201.14(a) Responsibility of licensee.