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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395408 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER Laurel Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 125 Holly Road Hamburg, PA 19526 | |

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) |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on facility policy review, clinical record review, review of facility documentation, staff interview, and resident interview, it was determined that the facility failed to ensure that residents were free from sexual abuse for one of six sampled residents (Resident 1) and on one of two nursing units (North Hall). This failure resulted in an Immediate Jeopardy situation. Findings include: Review of the facility policy entitled, Abuse Prohibition, last reviewed September 23, 2025, revealed that sexual abuse was defined as non-consensual sexual contact of any type with a patient and included, but was not limited to, sexual harassment, sexual coercion, or sexual assault. The facility was to implement an abuse prohibition program through investigation of incidents and allegations and protection of residents during investigations. The facility was to assign a representative from social services to monitor the resident's feelings and involvement in the investigation. Clinical record review revealed that Resident 1 had diagnoses that included muscle weakness. Review of the Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs) dated January 5, 2026, revealed that the resident was interviewable and did not have cognitive impairment. Review of the care plan revealed that the resident was dependent on staff for activities of daily living (ADLs) which included personal hygiene. Review of facility documentation revealed that on January 21, 2026, the resident reported that on the evening shift of January 20, 2026, nurse aide (NA) 1 washed her in a circular motion during incontinence care and stated, Do you like that? twice and flicked his tongue at her. The resident yelled at him to not say anything like that again. Review of facility documentation dated January 21, 2026, revealed that NA 2 wrote a statement, which indicated that on January 21, 2026, at 6:30 a.m., Resident 1 reported that during evening care the previous night, January 20, 2026, NA 1 cleaned her perineal (area located between the thighs) area in a circular motion and asked if she liked that. When the resident asked him to repeat himself to ensure she understood, he stated, Do you like that? a second time and flicked his tongue at her. Review of nursing schedules revealed that on January 20, 2026, NA 1 was assigned to work on the South Hall nursing unit, where Resident 1 resided. Clinical record review revealed that on January 20, 2026, NA 1 provided ADL care to Resident 1. In an interview on January 29, 2026, at 11:30 a.m., Resident 1 reported that during incontinence care, NA 1 folded and balled up multiple cleansing wipes at the start of care and used them to rub her vagina in an area she referred to as the man in the boat, which she stated was the area below the pubic hair, where the lips begin, in a circular motion. NA 1 then asked, Do you like that? When the resident responded with What? NA 1, stated Do you like it? Resident 1 reported that NA 1 was continually flicking his tongue, and his eyes were in a fixed stare. The resident reported that she felt NA 1 was trying to get a reaction out of rubbing her in that way. The resident reported that at that time, she yelled twice to NA 1, Don't you ever say anything like that to me again! The resident reported she was trying to think of a way to call for help. The resident reported that she was horrified inside, the vision of NA 1 during the encounter will stick with</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 395408 | If continuation sheet Page 1 of 4 |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>her, she felt everything she had done in life and her record was ruined, she was scared, she felt that she had been singled out, and she was upset that her family had to read about the incident. Resident 1 reported that she had not previously seen NA 1's tongue or mouth have any appearance or behavior that was similar to the flicking observed during the alleged violation. Resident 1 was tearful multiple times during this interview. Resident 1 stated that she was not informed of any new interventions, options for interventions, or updates to her care plan in the facility until January 28, 2026, seven days after the initial allegation. The resident was not aware of any measures that were implemented to protect her, following the allegation. Review of facility documentation dated January 27, 2026, revealed that a police officer provided the resident with victim's rights on that date. There was a lack of evidence that the resident was kept informed of the status of the investigation and new interventions, or provided with options for interventions until January 28, 2026. There was a lack of evidence that the resident's care plan was updated to address interventions to manage the potential for trauma until January 29, 2026. Review of facility documentation revealed that on January 21, 2026, the facility conducted interviews with eight residents and conducted physical assessments on 13 residents, all who resided on the same unit as Resident 1, South Hall nursing unit. Review of nursing schedules revealed that NA 1 was assigned to work on another nursing unit, North Hall, on January 7, 2026. In an interview on January 29, 2026, at 4:46 p.m., the Administrator confirmed that NA 1 worked on the North Hall nursing unit on January 7, 2026. There was no evidence that the facility interviewed or educated staff or conducted additional resident interviews or assessments as part of a thorough investigation to identify and protect other residents who may have been impacted on the North Hall nursing unit until January 28 and 29, 2026, over one week after the alleged incident occurred. In an interview on January 28, 2026, at 3:12 p.m., the Administrator confirmed that NA 1 had worked on North Hall nursing unit and that no additional resident interviews or staff education for that unit were initiated until January 28, 2026. On January 29, 2026, at 5:15 p.m., the Administrator was notified that the failure to protect residents from sexual abuse, constituted an Immediate Jeopardy situation at F600-K, related to the above and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility implemented the following corrective action plan: Resident 1 was assessed and offered emotional support. Resident 1's plan of care was updated. The resident would be followed by social services three times per week and as needed for emotional support and to determine indicators of post-traumatic stress disorder. The facility conducted interviews with staff and residents to identify any additional residents who may have been impacted. The police, Area Agency on Aging, and Pennsylvania Department of Aging were notified of the allegation of sexual abuse on January 21, 2026. The Administrator or designee re-educated 100 percent (%) of the management team on conducting a thorough investigation. 82% of staff were re-educated on reporting allegations of abuse or concerns about any staff member. 100% will be re-educated by the start of their next shift. Family members of non-interviewable residents will be contacted to identify any potential concerns of sexual misconduct by January 31, 2026. Identified concerns will initiate an immediate thorough investigation. The education regarding what constitutes a thorough investigation included: Ensure the alleged perpetrator is suspended and the residents are safe, identify and obtain statements from all staff that may have witnessed anything related to the incident, including staff not in direct care, identify all assignments/units where the perpetrator may have worked and interview all applicable residents, throughout an investigation the Abuse Critical Element Pathway would be reviewed to ensure all areas of a thorough investigation were reviewed and acknowledged. The Director of Nursing (DON) or designee will conduct interviews with five sampled residents</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>and five sampled family members to identify any potential allegations of sexual misconduct four times per week, then two times per month. Any identified concerns will result in an immediate, thorough investigation. The Market Operations Advisor educated the Clinical Lead on the expectations for review of completed audits four times per week, then two times per month. The Director of Nursing (DON) or designee will conduct interviews of five sampled staff members to identify any potential allegations of sexual misconduct four times per week, then two times per month. Any identified concerns will result in an immediate thorough investigation. The Market Operations Advisor educated the Clinical Lead on the expectations for review of completed audits four times per week, then two times per month. The alleged perpetrator was suspended and will continue to be suspended until the investigation is completed. The facility will follow appropriate protocol per policy and legal requirements. If the alleged perpetrator returns to work, he will be re-educated on the abuse policy and have random weekly observations of resident care 12 times. The results of the audits will be presented at the QAPI meetings for the review. The survey team validated that the Immediate Jeopardy was removed on January 29, 2026, at 9:30 p.m., after review of the facility training documentation, interviews, and review of facility policies and procedures following the facility's implementation of the corrective action plan for the Immediate Jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3)(e)(1) Management 28 Pa Code 201.29(a) Resident Rights 28 Pa Code 211.12(d)(1)(5) Nursing services</p> | | |

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| <p>F 0699</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on clinical record review, review of facility documentation, and resident interview, it was determined that the facility failed to assess triggers and develop and implement an individualized person-centered plan to render trauma informed care for a resident who was at risk for re-traumatization resulting in psychosocial harm for one resident. (Resident 1) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included muscle weakness. Review of the Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs) dated January 5, 2026, revealed that the resident was interviewable and did not have cognitive impairment. Review of the care plan revealed that the resident was dependent on staff for activities of daily living (ADLs), which included personal hygiene. Review of facility documentation revealed that on January 21, 2026, the resident reported that on the evening shift of January 20, 2026, nurse aide (NA) 1 washed her in a circular motion during incontinence care and stated, Do you like that? twice and flicked his tongue at her. The resident yelled at him to not say anything like that again. Review of facility documentation dated January 21, 2026, revealed that NA 2 wrote a statement which indicated that on January 21, 2026, at 6:30 a.m., Resident 1 reported that during evening care the previous night, January 20, 2026, NA 1 cleaned her perineal area in a circular motion and asked if she liked that. When the resident asked him to repeat himself to ensure she understood, he stated, Do you like that? a second time and flicked his tongue at her. In an interview on January 29, 2026, at 11:30 a.m., the resident reported that during incontinence care, NA 1 rubbed her vagina, in the area where the labia begin, with balled up cleansing wipes in a circular motion. NA 1 then asked, Do you like that? When the resident responded with, What? NA 1, stated, Do you like it? Resident 1 reported that NA 1 was continually flicking his tongue and his eyes were in a fixed stare. The resident reported that she felt NA 1 was trying to get a reaction out of her by rubbing her in that way. The resident reported that she yelled twice to NA 1, Don't you ever say anything like that to me again! The resident reported she was trying to think of a way to call for help. The resident reported that she was horrified inside, the vision of NA 1 during the encounter will stick with her, she felt that everything she had done in life and her record was ruined, she was scared, she felt that she had been singled out, and she was upset that her family had to read about the incident. Resident 1 was tearful multiple times during this interview. Resident 1 stated that she was not informed of any new interventions, options for interventions or updates to her care plan in the facility until January 28, 2026, seven days after the initial allegation. The resident was not aware of any measures that were implemented to protect her, following the allegation. In a confidential interview on January 29, 2026, at 2:59 p.m., a visitor of Resident 1's reported that the resident had been negatively impacted psychosocially by the alleged incident that was reported on January 21, 2026. Although clinical record review revealed that on January 22, 2026, social services spoke with the resident regarding inappropriate comments made by a staff member, there was a lack of evidence that the facility conducted a thorough assessment to identify the resident's trauma associated with the physical and verbal aspects of the allegation of sexual abuse to identify triggers and prevent re-traumatization. There was a lack of evidence that the facility discussed any new interventions, options for additional interventions, or updates to the care plan with Resident 1 until January 28, 2026. There was a lack of evidence that the facility implemented new, person-centered, interventions to render trauma informed care until January 29, 2026. 28 Pa. Code 211.12(d)(3)(5) Nursing services</p> | | |