STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395428	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Dauphin Nursing and Rehabilitation Center	990 Medical Road Millersburg, PA 17061

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on facility policy review, clinical record review, review of facility investigation documentation, and resident and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure each resident the right to be free from abuse, which resulted in actual harm as evidenced by multiple skin tears and penetrating wounds to the back of the head and neck after a resident to resident altercation for one of three residents reviewed (Resident 2). Findings Include:Review of facility policy, titled Abuse Policy, undated, revealed, in part, the resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.Review of Resident 1's clinical record revealed diagnoses that included paranoid schizophrenia (a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and anxiety disorder (intense, excessive and persistent worry and fear about everyday situations). Review of Resident 2's clinical record revealed diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke, hypertension (elevated blood pressure), and gastroesophageal reflux disease (GERD-acid reflux). Review of Resident 2's clinical record revealed a progress note written by Employee 1 (Registered Nurse [RN]), dated October 15, 2025, revealed that Employee 1 heard other staff yelling Resident 1's name and No. Employee 1 and Employee 2 (RN) both ran to Resident 2's room, where it was observed that staff were separating Resident 1 from Resident 2. The note further stated that Resident 1 was attacking Resident 2 with a pen. Resident 2 was immediately assessed for injury and was found with multiple skin tears and penetrating wounds to the back of the head/neck, with the tip of the pen found lodged inside one of the penetrating wounds. The pen tip was removed from Resident 2's neck, area was cleansed with NSS (normal saline solution) and TAO (triple antibiotic ointment) was applied. Further review of the note revealed that when Resident 2 was asked what happened, she stated [Resident 1] followed me in here. I said 'This is my room' and she told me 'I don't care', then started punching on me. Review of facility investigation revealed that the residents were immediately separated, the pen was removed from Resident 1 and Resident 1 was placed on a 1:1. At approximately 6:22 PM, Resident 1 was transferred to the emergency department on a 302 (an emergency psychiatric hold for individuals who are deemed a danger to themselves or others because of a mental illness).Review of Employee 3's witness statement dated October 15, 2025, revealed that Resident 2 was yelling for help. Staff ran to help and observed Resident 1 holding the back of Resident 2's wheelchair with her left hand and swinging at the back of Resident 2's head. It was then observed that Resident 1 had a pen in her hand. The statement further states that Employee 3 grabbed the pen while another staff member was directing Resident 1 away from Resident 2. Review of Employee 5's witness statement dated October 15, 2025, revealed that at 4:00 PM, after the Resident's smoke break, Employee 5 heard screaming. Employee 5 entered Resident 2's room and observed Resident 1 behind Resident 2's chair, and Employee 5 observed what appeared to be Resident 1 punching Resident 2 in the head. Employee 5 stated that as the residents were separated, Employee 5 noticed Resident 1 had a pen in her hand and had been stabbing Resident 2 in the neck. Employee 5 said she observed multiple marks on the back of Resident 2's neck as well as a mark on the back of her head. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on October 22, 2025, at 11:21 AM, they stated that they are unaware of any prior interactions between Resident 1 and Resident 2. They stated that the attack on Resident 2 was unprovoked and occurred right after both Residents attended smoking club. During an interview with Employee 6 (Activities Director), on October 22, 2025, at 12:20 PM, she stated that on October 15, 2025, during smoking club, there were no altercations between Residents 1 and 2. She stated that everyone seemed to be in a good mood and that Residents 1 and 2 did not even speak to each other. She further stated that where they sit during smoking club, they don't even face each other. At this time, Employee 7 (Activities) added that she was also present during smoking club on October 15, 2025. She stated that it was a normal smoking club activity and nothing was out of the ordinary involving either resident. During a surveyor interview with Resident 2 on October 22, 2025, at 12:28 PM, Resident 2 stated that Resident 1 came into Resident 2's room. Resident 2 told Resident 1 that wasn't her room and then Resident 1 pushed Resident 2 into her bed. Resident 2 stated that Resident 1 then started stabbing her. Resident 2 said at first, she thought Resident 1 was punching her but then realized she was being stabbed with a pen.