STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395494	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Slate Belt Health & Rehabilitation Center	701 Slate Belt Blvd, Rd 3 Bangor, PA 18013

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 Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on clinical record review, facility policy review, review of facility documentation, standards of nursing practice, and resident and staff interviews, it was determined the facility failed to prevent resident neglect that resulted in actual harm of a serious injury (fractured ribs and right patella - knee) for one of 12 residents reviewed. (Resident 10)Findings include: Review of Mosby's Textbook for Nursing Assistants, 11th edition dated January 2025, (comprehensive text used in nursing assistant training programs) revealed, when turning a person in bed you should turn the person toward you. Review of facility documentation titled, Resident Handling Quiz, revealed staff should roll the resident towards them while performing care in bed and when rolling a patient on a bed, staff should stand on the side of the bed to which the patient would roll. Review of the facility policy entitled, Safe Resident Handling and Body Mechanics Policy, dated November 18, 2024, revealed no specifics related to rolling a resident in bed. Review of Nurse Aide (NA) 1's training record revealed she was educated on resident handling, including bed mobility during care, on April 1, 2026. Review of Resident 10's clinical record revealed Resident 10 had diagnoses that included muscles weakness, Aphasia (difficulty speaking), and functional Quadriplegia (inability to use all four extremities due to an extreme physical limitation). Review of Resident 10's Minimum Data Set assessment (periodic assessment of resident needs) dated February 11, 2026, revealed Resident 10 had cognitive impairment and was totally dependent on staff for toileting and bed mobility. Review of Resident 10's clinical record revealed a nurse's note dated May 9, 2026 (6:10 a.m.), indicating Resident 10 rolled over the side of the bed away from the nurse aide and suffered a fall. Review of Resident 10's nurse's' notes on May 9, 10, and 11, 2026, revealed Resident 10 was complaining of right knee pain. Further review revealed on May 11, 2026, Resident 10 was sent to the emergency room where she was diagnosed with fractures (break or splinter of the bone into more than two fragments) of multiple right ribs and the right patella. Review of facility documentation dated May 9, 2026, revealed Nurse Aide (NA) 1 rolled the resident away from her to change her brief and the resident rolled off the other side of the bed. In an interview on May 28, 2026, at 10:20 a.m., Resident 10 stated I hurt and my leg. In an interview on May 28, 2026, at 1:30 p.m., the Director of Nursing confirmed that NA 1 failed to roll Resident 10 towards her during care. The Director of Nursing also confirmed that NA 1 was educated regarding this upon hire and that it would be expected that staff roll residents towards them during care as they are trained to do. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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