STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sinking Spring Skilled Nursing and Rehabilitation	3000 Windmill Road Sinking Spring, PA 19608

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility policy review, clinical record review, and resident and staff interview, it was determined that the facility failed to provide care and services in a manner that respected each resident's dignity and preferences to promote quality of life, resulting in psychosocial harm for one of seven sampled residents. (Resident 1)Findings include: Review of the facility policy entitled, Treatment: Considerate and Respectful, reviewed February 21, 2025, revealed that residents were to be groomed as they wished to be groomed, which included maintaining the resident's personal preference regarding hair style and length. Clinical record review revealed that Resident 1 had diagnoses that included chronic pain syndrome, major depressive disorder, and anxiety. The Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs) dated November 6, 2025, revealed the resident was alert and oriented, reported feeling down, depressed or hopeless several days per week, and was dependent on staff for assistance with personal hygiene. Review of Resident 1's care plan revealed that she often refused care due to her personal preference and staff was to postpone the activity if it was refused. Resident 1's care plan also indicated it was important for her to choose between a shower or bed bath. Review of Resident 1's nurse aide Kardex (list of resident care needs available to staff) revealed that staff were to complete a bed bath two times per week on Mondays and Thursdays. Review of the nurse aid documentation revealed that on January 6, 2026, Resident 1 was provided a shower. In an interview on January 8, 2026, at 10:20 a.m., Resident 1 stated she did not want to go for a shower and staff took her anyway. Resident 1 also stated that staff cut her hair using an electric razor despite her repeated refusals. Resident 1 was observed in bed. Her hair was visibly short and uneven with varying lengths of hair from close to the scalp to a half inch in length. The resident was observed to be rubbing her hand over her hair during the interview and moving her head from left to right. The resident further stated, It is bad enough the staff shaved my head, they didn't need to use an electric razor. I said no and they did it anyway. Resident 1 also stated, I used to have a ponytail, and they shaved it like I'm a prisoner. My hair looks horrible. They didn't need to shave it. They didn't even try anything else. In an interview on January 8, 2026, at 12:34 p.m., Nurse Aide 1 stated that her supervisor (the Director of Nursing) told her to cut Resident 1's hair. Nurse Aide 1 further stated that Resident 1 screamed no until after her hair was cut and then the resident just remained silent. In interviews on January 8, 2026, at 11:26 a.m., Nurse Aide 3, and at 12:43 p.m., Nurse Aide 4 both confirmed that Resident 1 stated she did not want to go for a shower, but that they provided her with one despite the refusal. In an interview on January 8, 2026, at 12:14 p.m., the Director of Nursing (DON) confirmed that she told staff to cut Resident 1's hair. The DON further stated that Resident 1 freaked the f out and said I don't want it off; it's a ponytail, and objected to staff cutting her hair. The DON also confirmed that scissors and an electric razor were utilized, and no other options were discussed or attempted. In an interview on January 8, 2026, at 1:26 p.m., Resident 2 (Resident 1's roommate) stated that after staff cut (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

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 0550 Level of Harm - Actual harm Residents Affected - Few	Resident 1's hair, Resident 1 was in the room crying.28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on facility policy review, clinical record review, observation, and resident and staff interviews, it was determined the facility failed to ensure that residents were free from physical and mental abuse for one of seven sampled residents. (Resident 1) This failure resulted in an Immediate Jeopardy situation.Findings include: Review of the facility policy entitled, Abuse Prohibition, last reviewed April 17, 2025, revealed that the facility prohibited abuse, mistreatment, and neglect for all residents. The policy further defined abuse as willful infliction, meaning the individual acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the facility policy entitled, Treatment: Considerate and Respectful, reviewed, February 21, 2025, revealed that residents were to be groomed as they wished to be groomed, which included maintaining the resident's personal preference regarding hair style and length. Clinical record review revealed that Resident 1 had diagnoses that included chronic pain syndrome, major depressive disorder, and anxiety. The Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs), dated November 6, 2025, revealed the resident was alert and oriented, reported feeling down, depressed or hopeless several days per week, and was dependent on staff for assistance with personal hygiene. Review of Resident 1's care plan revealed that she often refused care due to her personal preference and staff was to postpone the activity if refused. In an interview on January 8, 2026, at 10:20 a.m., Resident 1 stated that she was told by staff not to talk to anyone about certain things. The resident further stated, It is bad enough the staff shaved my head. They didn't need to use an electric razor. I said no and they did it anyway. Resident 1 also stated, I used to have a ponytail, and they shaved it like I'm a prisoner. My hair looks horrible. They didn't need to shave it. They didn't even try anything else. The resident reported that staff shaved her head and then took her to the shower after the incident. (Documentation indicated the shower occurred on January 6, 2026.) Resident 1 was observed in bed. Her hair was visibly short and uneven with varying lengths of hair from close to the scalp to a half inch in length. The resident was observed to be rubbing her hand over her hair during the interview and moving her head from left to right. During a confidential interview on January 8, 2026, at 12:00 p.m., staff confirmed that other staff shaved/cut Resident 1's hair on January 6, 2026, after lunch. In an interview on January 8, 2026, at 12:14 p.m., the Director of Nursing (DON) confirmed that she told staff to cut Resident 1's hair. The DON further stated that Resident 1 freaked the f out and said I don't want it off; it's a ponytail, and objected to staff cutting her hair. The DON also confirmed that scissors and an electric razor were utilized, and no other options were discussed or attempted. In an interview on January 8, 2026, at 12:34 p.m., Nurse Aide (NA) 1 stated that her supervisor (the DON) told her to cut Resident 1's hair. NA 1 further stated that Resident 1 screamed no until after her hair was cut, and then then the resident just remained silent. In an interview on January 8, 2026, at 1:26 p.m., Resident 2 (Resident 1's roommate) stated that following staff cutting Resident 1's hair, Resident 1 was in the room crying. There was no documented evidence that Resident 1 had tangled hair, medical need, or another condition requiring that her hair had to be cut. There was no documented evidence that Resident 1 was offered an alternative prior to the incident, including consultation with a hairdresser or a scheduled haircut. There was no documented evidence that the facility staff acknowledged Resident 1's refusal. On January 8, 2026, at 2:35 p.m., the Administrator was notified that the failure to identify and prevent physical and mental abuse during the above incident that occurred on January 6, 2026, constituted an Immediate Jeopardy situation at F600-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility implemented the following (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	corrective action plan: 1. Resident 1 was seen by social services on January 7, 2026, and psychiatry and the physician on January 8, 2026.2. The facility will conduct a full abuse investigation to be completed by January 8, 2026.3. The facility will report the allegation to the Department of Health, Pennsylvania Department of Aging, the local Police Department, and the Area Agency on Aging by January 8, 2026.4. Psychiatry/psychology services will continue to follow Resident 1 routinely.5. All residents will be assessed for injuries or trauma, with follow-up if needed, by January 8, 2026. If any allegations are brought forward, they will be reported to the abuse coordinator, the resident will be removed from the situation, and staff will be placed on leave if identified as the perpetrator. 6. The Administrator will re-review the abuse policy by January 8, 2026.7. The facility educated all staff in the facility on abuse protocols, resident rights, and the refusal of care. All staff that were available on January 8, 2026, were immediately educated. Other staff will be re-educated prior to the start of their next shift. Staff members will be given a quiz with the education. The facility suspended all involved staff members.8. Weekly audits for two weeks and then monthly audits will be conducted of any potential abuse allegations and the results discussed at QAPI (Quality assurance performance improvement) committee. The survey team validated that the Immediate Jeopardy was removed on January 8, 2026, at 7:43 p.m., through review of the facility training, interviews, and review of facility policies and procedures following the facility's implementation of the corrective action plan for the Immediate Jeopardy. CFR. 483.12 Freedom from Abuse, Neglect, ExploitationPreviously cited 3/27/2025 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(2)(3) 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.

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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. Based on clinical record review and resident and staff interview, it was determined that the facility failed to implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of seven sampled residents. (Resident 1)Findings include: Clinical record review revealed that Resident 1 had diagnoses that included chronic pain syndrome, major depressive disorder, and anxiety. According to the Minimum Data Set assessment (a periodic evaluation of resident care needs), dated November 6, 2025, the resident was alert and oriented, reported feeling down, depressed or hopeless several days per week, and was dependent on staff for assistance with personal hygiene. Review of Resident 1's care plan revealed that she often refused care due to her personal preference and staff was to postpone the activity if refused. In an interview on January 8, 2026, at 10:20 a.m., Resident 1 stated that staff cut her hair and took her for a shower, even though she refused. In an interview on January 8, 2026, at 12:14 p.m., the Director of Nursing confirmed that staff cut Resident 1's hair and took her for a shower on January 6, 2026, even though Resident 1 refused. There was no documented evidence that the facility postponed the activity per Resident 1's care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.