STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlen Hm of the Hungarian Rf of America	66 Carey School Road Ligonier, PA 15658

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical record, grievance investigations, reports submitted to the State, and staff interview it was determined that the facility failed to report an allegation of abuse for one of four residents reviewed (Resident R4). Findings include: Review of facility policy for Abuse, Neglect, Exploitation dated December 16, 2025, indicated that Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility will have procedures that includes reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated January 9, 2026, revealed that the resident was usually understood and could usually understand others, required assist from staff for daily care needs, and had diagnosis that included hemiplegia (paralysis or severe weakness affecting one side of the body) after a stroke, aphasia (language disorder that affects your ability to speak and understand what others say), and dementia. Review of a grievance decision report dated January 27, 2026, revealed that Resident 4's daughter had reported that the resident made hand gestures to the daughter indicating that a nurse was rough to roll him over and told him to shut up. The daughter expressed that the resident does not communicate/verbalize well, however he repeated the word shut up sixteen times and repeats night shift, heavy set, older. The daughter also stated that Resident 4 was laughing and making comments about how fun therapy was while she was visiting on January 23, 2026, and she visited again on Saturday, and reported that somewhere between Saturday night and Tuesday is when the incident may have occurred. The summary or pertinent findings of the grievance included that a Licensed Practical Nurse did recall the patient telling her about the allegation also, and the resident said dark hair in his description. Staff were educated/reminded that they are mandated reporters and are to report suspicious actions immediately to the supervisor. The facility's investigation regarding the mentioned grievance for Resident 4 dated January 27, 2026, included interviews that the Assistant Director of Nursing had completed with staff working during the identified time frame. One staff member reported that she was not rough and she did not witness anyone being rough with Resident 4, and that he described her as having dark hair. Interview with the Social Worker (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: 395552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlen Hm of the Hungarian Rf of America	66 Carey School Road Ligonier, PA 15658

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on February 2, 2026, at 2:30 p.m. revealed the Resident 4's daughter reported the allegation to her on the evening before Resident 4's discharge. The Assistant Director of Nursing was present at the time. The Social Worker revealed that she took notes, and asked questions, and had a suspicion of who the identified perpetrator could be based on the description given to her by the daughter and subsequent staff interviews, however, they were unable to positively identify the perpetrator Interview with the Assistant Director of Nursing on February 2, 2026, at 2:30 p.m. revealed that during her investigation, the night shift Licensed Practical that Resident 4 reported his allegation to was identified as Licensed Practical Nurse 1. The Assistant Director of Nursing revealed that although her notes did not reflect it, Licensed Practical Nurse 1 reported that Resident 4 revealed to her only that someone was rough with him and not that anyone told him to shut up. Administration was aware of the allegation of abuse on January 27, 2026; however, the resident had a planned discharge on [DATE], and the resident was not interviewed regarding the allegation prior to his discharge. The Assistant Director of Nursing confirmed that Licensed Practical Nurse 1 should have reported this allegation immediately but did not, and that the facility did not report this allegation to the Department of Health. 28 Pa Code: 201.14 (a) (c) Responsibility of management 28 Pa Code: 201.18 (b)(1) Management.