

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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 05/19/2026
NAME OF PROVIDER OR SUPPLIER Bethlen Hm of the Hungarian Rf of America		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, clinical records, and facility investigation reports, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out abuse or neglect as the cause of a bruise for two of four residents reviewed (Residents 3 and 4). Findings include: The facility's policy regarding resident abuse/neglect, dated December 16, 2025, revealed that possible indicators of abuse include but are not limited to (2) physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body. An investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of neglect or exploitation occur. Written procedures for investigation include identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witnesses, and any others who may have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred and the extent and cause; and providing complete and thorough documentation of the investigation. The facility's policy regarding incidents and accidents, dated December 16, 2025, revealed that the purpose of incident reporting can include assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve management of resident care; and conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement to avoid further occurrences. A quarterly MDS assessment for Resident 3, dated February 11, 2026, revealed that the resident had severe cognitive impairment, was dependent on staff for most daily care needs, and had diagnosis that included heart failure and anxiety. A nurse's note for Resident 3, dated April 15, 2026, at 4:46 a.m. revealed that a nurse aide reported that the resident had a bruise on her left forearm. The nurse observed a dark purple bruise four centimeters (cm) by two cm on the resident's left forearm. The Registered Nurse supervisor was notified and came to assess. The resident did not know how the bruise happened and had no complaints of pain or discomfort at the time. A facility injury investigation, dated April 14, 2026, at 10:00 p.m. revealed that Resident 3 had a bruise on her left forearm. The nurse observed a dark purple bruise four centimeters (cm) by two cm on the resident's left forearm. The Registered Nurse supervisor was notified and came to assess. The resident did not know how the bruise happened and had no complaints of pain or discomfort at the time. There was no documented evidence that a thorough investigation was completed to identify the root cause of the bruise or rule out abuse or neglect. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, revealed that the resident was usually understood and sometimes able to understand others, required assistance from staff for daily care needs, and had diagnosis that included dementia. A nurse's note for Resident 4, dated March 29, 2026, at 6:23 p.m. revealed that the resident's son called and reported observing a bruise on the resident's right forearm during his visit yesterday. The son inquired if there was any prior documentation regarding this bruise. This nurse informed him that there was currently no documentation on that bruise but was reassured that a full assessment would be completed to assess for any additional bruises. Bruise to right forearm measured approximately six cm by nine cm and was yellow and green in color. Additionally, there were two small bluish-purple bruises noted to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395552	If continuation sheet Page 1 of 2

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents left shin. No other bruising was noted at the time. Resident was an unreliable historian and unable to provide accurate information regarding the origin. The Registered Nurse and the Assistant Director of Nursing were made aware, and a message was left for the resident's son regarding the assessment findings. Review of a grievance filed for Resident 4 dated March 30, 2026, revealed that the resident's son had noticed a fist sized bruise on the resident's right arm and that the facility would interview staff that provided care, and the resident. A facility injury investigation, dated March 29, 2026, at 1:15 p.m. revealed that resident's son called and reported observing a bruise on the residents right forearm the day prior during his visit. This nurse asked the resident to see her arm and observed a yellow/green bruise measuring approximately six cm by nine cm. When asked if she remembered what happened the resident stated, three girls held me down. The resident's son expressed that he knows his mom is unable to give a reliable description because of her diagnosis, but she did tell him it was caused by a girl the day prior when he asked. Interview with the resident revealed that she stated I am [AGE] years old, and my memory is not very good. But I was in a place and there was some girls cleaning up and they tried to get me to go somewhere and they pulled on me. I think that is where that came from. I have had it for weeks. My neck also hurts and maybe it is from that too. Resident did not have any other bruises on her arm or her neck. She stated well, then maybe I made that up too? I don't really know. There was no documented evidence that staff were interviewed to identify if any abuse/neglect may have occurred. A nurse's note for Resident 4, dated April 28, 2026, at 11:14 a.m. revealed that an aide notified the nurse that there was bruising to the resident bilateral upper extremities and her right lower extremity. The resident was asked if she bumped into anything and she reported to this nurse not that she was aware of. She was asked by this nurse if anyone had grabbed her, and the resident reported Not as far as I know. A registered nurse assessment, vital signs were stable, resident had no pain or discomfort, skin was intact, and doctor and son were notified. A facility injury investigation, dated April 28, 2026, at 11:04 a.m. revealed that a nurse aide notified the nurse that there was bruising to bilateral upper extremities and her right lower extremity. The resident was asked if she bumped into anything and she reported to this nurse not that she was aware of. She was asked by this nurse if anyone had grabbed her and the resident reported Not as far as I know. There was no documented evidence that a thorough investigation was completed to identify the root cause of the bruise or to rule out abuse/neglect. Interview with the Director of Nursing on May 19, 2026, at 3:45 p.m. confirmed that a thorough investigation was not completed to attempt to identify the root cause of a bruise or rule out abuse/neglect related to the bruises on Residents 3 and 4 on the above-mentioned dates. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		