

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

Printed: 10/09/2026
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 07/13/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of clinical records, the facility's investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that fall interventions were in place for one of seven residents reviewed (Resident 1), and failed to ensure that safety interventions were in place for one of seven residents reviewed (Resident 2). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 22, 2026, indicated that the resident was cognitively impaired, dependent on staff for daily care needs and had diagnoses that included Dementia and Parkinsonism (a group of movement disorders such as muscle stiffness and balance issues). A fall risk assessment for Resident 1 dated June 15, 2026, at 6:25 p.m. revealed that Resident 1 had fall risk score of 18, which indicates a high risk for falls. A care plan dated June 16, 2026, indicated Resident 1 was at risk for falls or injury with goals and interventions in place. A nursing note for Resident 1, dated June 29, 2026, at 1:20 p.m., revealed that the resident had a fall out of her wheelchair while reaching for her walker to transfer. Resident 1 was assessed and had no injuries or complaints of pain. An incident report for Resident 1, dated June 29, 2026, revealed that after Resident 1 was assessed she was assisted to her wheelchair. A recommendation to prevent reoccurrence was to put a sign on her walker. There was no documented evidence that a new intervention was put in place to prevent future falls. A nursing note for Resident 1, dated July 11, 2026, at 1:43 a.m. revealed that the resident observed laying on her back on the floor in front of the tv stand. Resident 1 was assessed and was found to have a bruise to her right lower back and her left hand. An incident report for Resident 2, dated July 12, 2026, revealed that after Resident 1 was assessed she was assisted to the bathroom and then to bed. A recommendation to prevent reoccurrence was attempt to resident to call for help before getting up and check on her frequently. There was no documented evidence that a new intervention was put in place to prevent future falls. A quarterly MDS assessment for Resident 2, dated May 6, 2026, indicated that the resident was cognitively impaired, required substantial assistance for daily care needs and had diagnoses that included Altered mental status. A care plan for Resident 2 dated August 24, 2024, revealed that the facility was to ensure safety for Resident 2 and others. A nursing note for Resident 2, dated July 1, 2026, at 6:01 p.m. revealed that the resident was observed several times throughout the shift becoming aggressive and agitated, believing that she works here and expresses frustration that everybody (other residents) is not doing anything/lazy and should be working. Resident 2 was observed ramming her walker into several staff and fellow residents. Interview with Nursing Home Administrator and Director of Nursing July 13, 2026, at 1:15 p.m. revealed that when Resident 2 wants to leave an area of the facility she just pushes on whatever is in her way. A physical aggression report for Resident 2 dated July 1, 2026, at 11:30 a.m. revealed that Resident 2 was ramming her walker into fellow residents and staff. There was no documented evidence that (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were in place to ensure the safety of Resident 2 and others. An interview with the Nursing Home Administrator and Director of Nursing on July 13, 2026, at 2:00 p.m. confirmed that there should have been new interventions in place to prevent future falls for Resident 1 and that there were no interventions in place to ensure safety for Resident 2 and others. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.		