STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395571	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muncy Place	215 East Water Street Muncy, PA 17756

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to protect residents from staff neglect by implementing interventions to prevent falls for two of four residents reviewed (Residents 1 and 2) resulting in harm to include a fracture for one of two residents reviewed (Resident 2). Findings include: The facility policy entitled, Abuse: Prevention, Investigation, and Reporting, last reviewed without changes on June 4, 2025, revealed that Resident abuse is defined as any act of omission or commission, which may cause or does cause actual physical, psychological, or emotional harm or injury to a resident. Neglect means the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, treatments and care, including but not limited to nutrition, medication, therapies, and activities of daily living. The absence of reasonable accommodations of individual needs and preferences may result in resident neglect. Examples cited included the failure to provide safety precautions. Training employees included that all employees would be provided with in-service training following any incident regarding abuse, neglect, mistreatment of residents, or misappropriation of property. Identification of Abuse listed components that included that in the incident report a description of the scene, positioning of the resident, witnesses, time and nature of injury will be included. The staff member completing the investigation will investigate a minimum of eight hours prior to the known injury to determine cause. Protection of resident(s) during the investigation included that residents are protected from harm during the investigation from all involved parties. Components listed under Investigation of Abuse included that all allegations of abuse, neglect, mistreatment of resident, or misappropriation of property will be reported immediately to the supervising nurse. The Director of Nursing is the abuse prevention officer. The Director of Nursing or designee will be notified immediately of any suspected or alleged abuse. Written, signed statements will be obtained from the resident, the alleged offender/offenders, and witnesses. All involved parties will be interviewed by the person conducting the investigation. The Administrator or designee will continue the investigation by gathering information to complete all sections of the PB-22, Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property. Employees suspected of resident abuse, neglect, mistreatment of residents or misappropriation of property will be suspended pending investigation and subject to SH Corrective Action Procedures. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Clinical record review for Resident 1 revealed Kardex documentation (electronic documentation available to nurse aide staff that lists resident care needs) that stipulated Resident 1 required Safety/Precautions: Safety Alarms. Review of Resident 1's comprehensive care plan revealed interventions that included, Bed alarm when in bed. Nursing documentation dated May 3, 2025, at 4:15 PM revealed that nurse aide staff found Resident 1 on the floor with bleeding above her left eye. Upon assessment, staff noted Resident 1 had a laceration above her left eye, a bump on her forehead, and a bump above her left eye and on her left cheek. Staff called emergency medical services (EMS, 911) to transport Resident 1 to the hospital emergency room (ER). Nursing documentation dated May 3, 2025, at 7:40 PM noted that Resident 1 returned from the ER; and was assessed to have a black eye and bruising to left check (sic) Laceration of the left eyebrow, traumatic contusion (soft tissue injury of blood vessels resulting in swelling and discoloration) of left periorbital (area around the eye) region. Per report from (ER registered nurse) four or five absorbable sutures placed in the left eyebrow, also she has a small laceration below the left eye, which was not sutured, band aid in place. Review of an Incident/Accident Evaluation (form the facility utilizes to document the outline of an incident investigation) dated May 3, 2025, at 3:25 PM revealed that Resident 1's bed alert was not alarming upon checking alarm was not turned on, resident noted to have bleeding above her left eye, upon assessment resident noted to have a laceration above left eye, bump on forehead and bump above left eye and on left cheek. Review of the PB-22 (Provider Bulletin 22, form electronically submitted to the Department when an event is investigated for potential abuse, neglect, or misappropriation of property) for the incident dated May 3, 2025, at 3:24 PM confirmed that the facility substantiated resident neglect. Employee 3 (registered nurse) provided a statement that Employee 1 (nurse aide) attested that she placed Resident 1 in her bed the afternoon of May 3, 2025, prior to her fall. Resident 1's POC (plan of care) was not followed as Resident 1's fall alarm was not sounding at the time of the fall. Employee 3 stated, (Employee 1) assisted (Resident 1) in bed after lunch, the alarm box was present on the bed, but she did not check to ensure the alarm engaged. The facility's findings were that Employee 1 did not check to ensure Resident 1's safety alarm on her bed was functioning before exiting her room after placing her in bed. The facility's corrective action was to provide education to Employee 1. Employee 4 (assistant director of nursing) documented that the PB-22 was completed on May 6, 2025, at 2:54 PM. The PB-22 did not include information to suggest that the facility suspended Employee 1 pending the outcome of the investigation or provided all employees in-service training following the above incident of substantiated resident neglect. Review of Employee 1's timecard revealed that she worked May 3, 2025, from 10:33 AM to 11:03 PM; May 4, 2025, from 10:32 AM to 11:10 PM; and May 6, 2025, from 10:40 AM to 10:57 PM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Documentation of Supervisor Counseling (form the facility utilizes to record verbal warnings between a staff member and their supervisor) dated May 6, 2025, for the issue/violation that occurred on May 3, 2025, noted a summary of a conversation with Employee 1 and her response. The form indicated that the supervisor (noted as Employee 4) explained to Employee 1 the necessity of always checking fall prevention measures. The counseling documented for Employee 1 was dated three days after the incident with Resident 1, and Employee 1 was permitted to work with a resident assignment without evidence of a suspension per the facility policy. Interview with the Nursing Home Administrator on June 9, 2025, at 9:05 AM revealed that the facility has scheduled in-service training for all staff on June 11, 2025, that includes the topic of abuse prevention, investigation, and reporting. The interview indicated that (other than the scheduled in-service for all staff) individual registered nurse supervisor trainings are provided with an alleged perpetrator as documented in the completed PB-22s. Clinical record review for Resident 2 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that assessed Resident 2 as dependent for rolling left to right, to change from sitting to standing, for personal hygiene, and for toileting hygiene (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity). Review of Resident 2's Kardex documentation stipulated that Resident 2 required the assistance of two staff for bed mobility. Nursing documentation dated May 31, 2025, at 1:17 PM that Resident 2 was in bed receiving care from two nurse aides. During care, Resident 2 rolled out of bed and landed on the floor, in a sitting position. Staff heard two loud pops, and assisted Resident 2 to a lying position on the floor. Staff called 911. Resident 2 presented with a bruise on her right knee that staff documented as 3x6 (no unit of measurement provided). A paramedic arrived and assessed Resident 2, straightened her lower extremities, reported that Resident 2's left kneecap was subluxed (partial separation of a joint), and he popped it back into place. Two emergency medical technicians arrived, and Resident 2 was transferred off the floor to a stretcher with the assistance of four people. Review of a witness statement from Employee 5 (nurse aide) relating to Resident 2's fall on May 31, 2025, at 11:50 AM revealed that he was in the bathroom to get washcloths and the wheelchair for Resident 2's care. He heard she's on the floor. He walked out to see Resident 2 sitting against the side of her bed with her legs, almost Indian style. He attempted to help her to the ground softly and (he) heard a pop and immediately called for the nurse. Review of a witness statement from Employee 2 (nurse aide) relating to Resident 2's fall on May 31, 2025, at 11:50 AM revealed that she was rolling Resident 2 to the enabler bar. (Employee 5) was present, but he went to grab the wheelchair. As Employee 2 was proceeding with care her (Resident 2) lower half started sliding along with her upper half. Her upper body was on the bed as she was sitting Indian style. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Neither staff statement indicated that the Director of Nursing or Nursing Home Administrator was notified of Resident 2's fall as a result of not following her plan of care (i.e., alarms, level of assistance, gait belt, fall mats). Review of a PB-22 in response to Resident 2's fall on May 31, 2025, at 12:00 PM revealed the facility's description of the incident was that Employee 5 was in the bathroom gathering supplies for care and Resident 2's wheelchair when Employee 2 continued with care. Resident 2 rolled towards the enabler bar, her lower body began sliding off the bed, and her legs were mal aligned on the floor. Staff members heard a pop, 911 transferred Resident 2 to the ER, and at the ER diagnostics completed revealed an acute right distal femoral fracture (break in the lower part of the thigh bone). Resident 2 was admitted to the hospital for planned surgical intervention. The facility substantiated neglect for the failure to utilize two staff members per Resident 2's bed mobility care guidelines. Employee 4 documented that the PB-22 was completed on June 4, 2025, at 1:35 PM. Review of Documentation Supervisor Counseling forms dated May 31, 2025, revealed that the registered nurse supervisor counseled Employees 2 and 5 regarding staying at the bedside when Resident 2 is positioned on her side to prevent falls. Employee 5 reiterated his statement that he was not present at the bedside when Resident 2 was initially rolled on her side in bed. He was in the bathroom gathering supplies to do care to get Resident 2 out of bed when he heard the nurse aide state that she was on the floor. He did not witness the fall. Review of Employee 2's timecard revealed that she worked May 31, 2025, from 11:02 AM to 10:57 PM; June 1, 2025, from 6:47 AM to 7:03 PM; and June 2, 2025, from 2:37 PM to 11:04 PM. There was no evidence that the facility suspended Employee 2 pending the outcome of the investigation of Resident 2's fall (and substantiated neglect) on May 31, 2025. There was no evidence that the facility provided all employees in-service training following Resident 2's incident of substantiated neglect. The surveyor confirmed the above findings regarding the fall incidents for Residents 1 and 2 with the Director of Nursing, the Nursing Home Administrator, and Employee 4 on June 9, 2025, at 5:00 PM. The facility failed to ensure that staff implemented resident interventions identified as necessary in the residents' care plan to avoid accident and injury for Residents 1 and 2. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(e)(1) Management 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(d) Staff development 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services