STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395605	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Barnabas Nursing Home	5827 Meridian Road Gibsonia, PA 15044

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 records, facility provided documents, reports submitted to the State, and staff interview it was determined that the facility failed to report an allegation of abuse for one of three residents (Resident R3).Findings include: Review of facility policy Prohibition and Prevention of Resident Abuse, Neglect, Exploitation, Mistreatment, or Misappropriation of Resident Property dated 12/9/25, indicated all allegations of abuse must be reported initially through the Electronic Event Reporting system (ERS). Emotional or psychological abuse - the verbal or nonverbal infliction of anguish, pain or distress that results in mental or emotional suffering. Taking or using photos or recordings in any manner that would demean or humiliate a resident. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE], with the diagnoses of right humeral fracture (a break in the upper arm bone), pain, and high blood pressure. Review of Behavior Night Shift Documentation dated 3/8/26, indicated Resident R3 called 911 and was attempting to take photos of other residents without their consent. Interview on 3/11/26, at 10:30 a.m. Resident R3 indicated everything was fine until resident called the police and the facility turned everything around on resident and removed resident's roommate Resident R4 out of the room. Interview on 3/11/26, at 12:00 p.m. the Director of Nursing indicated Resident R4's family indicated to Resident R3 to watch out for their loved one. Resident R3 took that statement too seriously and was photographing Resident R4. Resident R4 always had full clothing on in the photos. Review of the facility's ERS reports failed to include a report of alleged abuse as required. Interview with the Director of Nursing on 3/11/26, at 1:00 p.m. indicated the facility didn't realize it was reportable and failed to report an allegation of abuse for one of three residents (Resident R3). 28 Pa Code: 201.14 (a)(c)(e) Responsibility of management28 Pa Code: 201.18 (b)(1) (e)(1) Management.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure a resident received appropriate behavioral health management to maintain the highest practicable well-being for one of three sampled residents (Resident R1).Findings include: Review of the facility policy Behavioral Management Programs dated 12/9/25, indicated the facility will provide behavioral management programs for those patients who exhibit behavioral problems that will maximize their psychosocial well-being. The program will promote non-medical interventions. Implemented for those patients with a recurring behavior that is deviant from that which is commonly regarded as acceptable by normal standards. Review of the admission record indicated Resident R1 admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), cognitive impairment of unknown etiology, and Parkinson's Disease (disorder of the nervous system that results in tremors). Section C0500 indicated a Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) score of two - severe cognitive impairment. Section Behaviors - E0200 indicated C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1. Behavior of this type occurred one to three days. Review of Resident R1's current care plan indicated the resident has a potential for behavioral problem due to cognitive impairment. The resident will have no evidence of behavior problems such as sexually inappropriate towards staff by review date. Interventions included:-Anticipate and meet the resident's needs.-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.-Praise any indication of the resident's progress/improvement in behavior. Review of Activity Interview for Daily and Activity Preferences dated 1/24/26, indicated:- it was somewhat important for Resident R1 to have books, newspapers, and magazines to read. -it was very important to listen to the music they like.-it was very important to be around animals such as pets.-it was very important for resident to do their favorite activities.-it was very important to go outside to get fresh air when the weather is good. Review of Resident R1's Behavior Day Shift Documentation dated 1/25/26, indicated numerous attempts to disrobe in the hallway. Review of Resident R1's Behavior Day Shift Documentation dated 2/13/26, indicated exposing and manipulating penis. Review of facility provided documentation dated 2/13/26, indicated Resident R2 stated while they were placed in the dining room area by a Physical Therapist, a male resident (Resident R1) was behaving inappropriately. Our review of the allegation regarding the male resident determined that the individual in question has advanced dementia and lacks awareness of their surroundings. On one occasion, Resident R1 was observed at the nurses' station with clothing displaced due to confusion. Review of progress note dated 2/13/26, at 7:51 a.m. indicated patient reports that they are upset after seeing another resident perform masturbation in the common area. This has been reported to nursing and administration. Observation on 3/11/26, at 9:30 a.m. Resident R1 was observed at the nurses' station in a reclining medical wheelchair placed at the desk beside the Unit Secretary Employee E1. There was nothing provided to Resident R1 for stimulation or diversional activity. Interview with Unit Secretary Employee E1 on 3/11/26, at 10:28 a.m. indicated their position was non-medical in nature and they sat with Resident R1 to watch them. Interview on 3/11/26, at 10:32 a.m. Registered Nurse (RN) Employee E2 indicated Resident R1 disrobes frequently, at times manipulates his penis and staff try to redirect resident but aren't always successful. Also indicated staff can't leave resident in the room because resident is a fall risk. Interview on 3/11/26, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER St Barnabas Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5827 Meridian Road Gibsonia, PA 15044	

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:09 p.m. Nurse Aide (NA) Employee E3 indicated Resident R1 removes their clothes daily, sometimes manipulates penis and pulls it out of the clothing. Resident R1 also behaves this way when resident's spouse is present. Interview on 3/11/26, at 2:00 p.m. the Director of Nursing confirmed the facility failed to ensure a resident received appropriate behavioral health management to maintain the highest practicable well-being for one of three sampled residents (Resident R1). 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 211.12(c)(d)(3) Nursing services