STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395616	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lock Haven Rehabilitation and Senior Living	22 Cree Drive Lock Haven, PA 17745

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. Based on review of select facility policies and procedures, facility documents, clinical record review, and resident and staff interview, it was determined that the facility failed to thoroughly investigate and report an allegation of abuse for one of five residents reviewed (Resident 4).Findings include: Review of the facility's current policy entitled Abuse Prevention and Prohibition Program, revealed the purpose of the policy is to ensure the facility establishes, operationalizes, and maintains and abuse prevention and prohibition program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with the federal and state requirements. The policy indicated the facility is to promptly and thoroughly investigate reports of resident abuse, mistreatment, neglect, injuries of unknown source, and criminal acts. During an interview with Resident 4 on January 30, 2026, at 12:01 PM the resident stated, staff are great, but I had trouble with two of them quite a while ago and I had bruises on both of my arms. Resident 4 could not give a specific date of the incident occurring or staff names, but stated staff came and told her it would never happen again. Clinical record review for Resident 4 revealed a late entry nursing progress note documented on January 20, 2026, at 2:15 PM for January 19, 2026, at 2:15 PM that noted staff went to speak to the resident regarding her being mad at the night shift nurse aides. It was noted staff discussed with the resident her concern that the nurse aides grabbed her hands and she had bruising from it. The resident stated the nurse aides were changing her, she did not like how they were changing her, they grabbed her hands, and now she had bruises. The resident also stated they were laughing while doing her care. The same note indicated bruising was present on the resident's right dorsal (back) hand by her thumb measuring 1.5 cm (centimeters) by 1.8 cm and purple in color. It was also noted that a 2.0 cm by 2.0 cm purple bruise was identified on the residents left dorsal wrist area. The note indicated the nurse aides reported the resident was attempting to kick, bite, and was swinging her arms at them and felt the bruising could have come from that. They indicated that they were smiling and laughing because the roommate was making funny comments to them while they were providing care. A nursing note dated January 19, 2026, at 10:20 PM for Resident 4 noted bruising on top of both hands, stated two girls at night grabbed her hard and left bruising on both hands and the incident was reported to nursing administration. A nursing note dated January 20, 2026, at 6:57 PM for Resident 4 noted bruising to bilateral hands/wrists continues with no complaints of pain. A nursing note dated January 21, 2026, at 9:40 AM for Resident 4 noted the interdisciplinary team met to discuss bruising, and the investigation was completed and the bruising was consistent with combative behaviors. Review of a facility report dated January 19, 2026, for Resident 4 indicated an incident involving the skin for the resident was identified. The report did not indicate any incident of alleged abuse but indicated two staff members were involved in the incident. The report reviewed the bruises noted above and indicated the resident (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being combative with care was the likely cause of the injuries. The report included statements from the two staff members who were noted to be involved in the incident, and one additional staff member who noted the resident was heard screaming and was then observed being combative with care. There was no evidence statements were obtained from additional staff who were working at the time of the alleged incident on or near Resident 4's unit, from the resident's roommate who staff indicated was present during the incident, or any other residents who were cared for by the employees alleged to be involved in the incident to rule out potential abuse. There was no evidence that facility staff reported the allegation of abuse alleged by Resident 4 to the appropriate agencies (e.g., the local field office for the Department of Health). In an interview with Employee 2, Assistant Director of Nursing, on January 30, 2026, at 1:05 PM they indicated the facility did not identify a need to report the incident as an allegation of abuse to the local field office as they determined abuse did not occur. Interview with the Nursing Home Administrator and Director of Nursing on January 30, 2026, at 3:30 PM revealed that they did not report or more thoroughly investigate the above alleged incident of abuse reported by Resident 4. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights