STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395648	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peter Becker Community	800 Maple Avenue Harleysville, PA 19438

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, employee file review, and staff interview, it was determined that the facility failed to ensure employees completed required abuse training in a timely manner for one of five newly hired employees. (Employee 1)Findings include: Review of the facility policy entitled, Abuse Prevention and Investigation, last reviewed August 19, 2025, revealed that all staff would receive abuse prevention training during orientation and annually thereafter. Review of employee files revealed the following: Employee 1 (E1) had been working at the facility as a licensed practical nurse since April 20, 2026. There was a lack of evidence that the employee had completed abuse training until April 26, 2026, six days after they started working in the facility. In an interview on May 13, 2026, at 11:20 a.m., the facility scheduler confirmed that E1 was working amongst residents starting on April 20, 2026. In an interview on May 13, 2026, at 1:50 p.m. the [NAME] President of Human Resources confirmed that E1 did not complete the abuse training until April 26, 2026, six days after they started working with residents in the facility. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(3)(7)(8) Personnel policies and procedures.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395648	A. Building B. Wing	05/13/2026

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for one of two sampled residents with limited range of motion. (Resident 6)Findings include: Clinical record review revealed that Resident 6 had diagnoses that included Parkinson's disease, Alzheimer's disease, dementia, and chronic pain syndrome. The Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment, had impaired bilateral upper and lower extremities, and was dependent on staff for personal hygiene and dressing. On March 1, 2026, the physician ordered that staff apply bilateral hand splints for contractures every morning at 9:00 a.m., and remove the hand splints every evening at 9:00 p.m. Observations on May 12, 2026, at 10:45 a.m., and 12:20 p.m., and on May 13, 2026, at 10:52 a.m., revealed that Resident 6 did not have the hand splints in place and the resident's hands were observed tightly contracted. In an interview on May 13, 2026, at 1:58 p.m., Employee 2 confirmed that the resident was identified with a contracture to her bilateral hands and that the bilateral hand splints should have been in place as ordered when the resident was observed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.