STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395671	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southmont of Presbyterian Seniorcare	835 South Main Street Washington, PA 15301

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to protect a resident from neglect that resulted in actual harm of a left distal fibula (lower leg above the ankle) fracture for one of five residents reviewed (Resident R1). This was identified as harm for past non-compliance. Findings include: Review of facility document entitled, Corporate Compliance-Abuse Neglect dated 11/20/24, revealed neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Review of Resident R1's admission record indicated resident was admitted to the facility on [DATE]. Review of the Minimum Data Set assessment (MDS- periodic assessment of resident care needs) dated 8/8/25, included diagnoses of Arthritis, High Blood Pressure, Depression, and Osteoporosis (decrease in the amount of bone tissue). Resident R1 is alert and oriented and able to make needs known. Review of the MDS assessment dated [DATE], Section GG: Functional Abilities, Section GG0170 revealed Resident R1 was dependent on staff for bed to chair transfer. Review of Resident R1's plan of care for ADL (activities of daily living) Self Care performance deficit-related to arthritis dated 10/11/24, requires resident to have an assist of two staff for toileting. Review of Resident R1's [NAME] Board (listing of ADLs, continence levels, and behaviors, which generates directly from the resident care plan) utilized by nurse aide staff dated 10/20/25, revealed Resident R1 requires two or more staff helpers for transfers. Review of Resident R1's progress note dated 10/22/25, revealed Resident R1 complained of pain in left lower leg/ankle. The resident indicated the staff transferred [him/her] the last two nights and [resident] bumped [his/her] leg on something. New orders for x-ray to LEE (left lower extremity). Review of facility incident report dated 10/23/25, revealed the resident complained of left lower leg pain with weight bearing and an x-ray was ordered. Review of Resident R1's x-ray report dated 10/22/25, revealed Resident R1 sustained a fracture to the left distal fibula. Review of CNA (Certified Nurse Aide) Employee E1's statement dated 10/22/25 indicated I took the resident to the bathroom and put [Resident] on the bedside commode. The resident stated to be careful of my leg and was in pain. I hurt [Resident] when I took [Resident] to the bathroom. Review of CNA Employee E1's personnel file revealed a hire date of 7/14/25, and Employee E1 received CNA training and competencies in the ability to confirm appropriate transfer methods per the plan of care, assisting with transfers, and transferring residents safely, completed on 8/28/25. Review of the facility report submitted on 10/23/25, for Investigation of Alleged Abuse, Neglect, Misappropriation of Property revealed Employee E1 attempted to transfer Resident R1 without an assist of two persons as required and was terminated. During an interview on 11/12/25, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to protect a resident from neglect that resulted in actual harm for one of six residents which resulted in actual harm of a fractured left fibula to Resident R1. On 10/23/25, the facility-initiated education for all direct care nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides (NAs) to ensure ordered transfer guidelines were understood and followed appropriately. This plan included the following: -Immediate termination of NA Employee E1.-Facility completed a full house audit to ensure correct transfer status was documented for each resident.-Education was provided on 10/23/25, to all nursing staff on abuse and neglect.-Audits and education were reviewed with the Quality Assurance and Performance Improvement Committee for trends and outcomes. During interviews on 11/12/25 from 10:40 a.m. to 2:30 p.m., the following was revealed: CNA Employee E2 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. CNA Employee E3 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. CNA Employee E4 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. CNA Employee E5 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. CNA Employee E6 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/32/25. CNA Employee E7 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. CNA Employee E8 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record reviews, and staff interview, it was determined the facility failed to provide adequate supervision during transfer to prevent injury which resulted in the actual harm to Resident R1 of a leg fracture for one of five residents. This was identified as harm for past non-compliance. Findings include: Review of facility policy titled, Skilled Nursing-Lifting and Transferring Residents dated 11/20/24, revealed the facility will minimize the risk of injury to residents and transfer residents as safely as possible. Physical therapy will evaluate and recommend transfer status and the physician will obtain an order specifying resident transfer status. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of Minimum Data Set assessment (MDS, periodic assessment of resident care needs) dated 8/8/25, included diagnoses of Arthritis and high blood pressure. Review of Section G: revealed Resident R1 was dependent (requiring assist of two helpers) for transfer from sit to stand. Resident R1 is alert and oriented and able to make needs known. Review of Resident R1's physician order dated 5/12/25, revealed Resident R1 required an assist of two staff members for toileting/transfers. Review of Resident R1's plan of care for ADL (activities of daily living) Self Care performance deficit-related to arthritis dated 10/11/24, requires resident to have an assist of two (staff members) for toileting. Review of Resident R1's progress note dated 10/22/25, revealed Resident R1 complained of pain in left lower leg/ankle. The resident stated the staff transferred [Resident] the last two nights and [he/she] bumped [his/her] leg on something. New orders obtained for x-ray scan for LEE (left lower extremity). Review of Resident R1's x-ray report dated 10/22/25, revealed Resident R1 sustained a fracture to the left distal fibula. Review of facility incident report dated 10/23/25, revealed Resident R1 complained of left lower leg pain with weight bearing subsequently x-ray was ordered. Review of NA (Nurse Aide) Employee E1's written statement dated10/22/25 revealed, I took the resident to the bathroom and put [him/her] on the bedside commode. The resident stated to be careful of my leg, and [Resident] was in pain. I hurt [Resident] when I took [him/her] to the bathroom. Review of NA Employee E1's personnel file indicated a hire date of 7/14/25, and Employee E1 received nurse aide training and competencies in the ability to confirm appropriate transfer methods per the care plan, assisting with transfers, and transferring residents safely, completed on 8/28/25. Review of facility documentation dated 10/21/25, for Investigation of Alleged Abuse, Neglect, Misappropriation of Property submitted 10/23/25 revealed Employee E1 attempted to transfer Resident R1 without an assist of two persons deemed safety required and was subsequently terminated. During an interview on 11/12/25, at approximately 3:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide sufficient supervision to prevent injury which resulted in the actual harm of a leg fracture for Resident R1. On 10/23/25, the facility-initiated education for all direct care nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides (NAs) to ensure that ordered transfer guidelines were understood and followed appropriately. This plan includes the following: -Immediate termination of NA Employee E1.-Facility completed a full house audit to ensure correct transfer statuses were documented for each resident.-Education was provided on 10/23/25, to all nursing staff on abuse and neglect.-Audits and education were reviewed with the Quality Assurance and Performance Improvement Committee for trends and outcomes. During interviews on 11/12/25 from 10:40 a.m. to 2:30 p.m., the following was revealed: NA Employee E2 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. NA Employee E3 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. NA Employee E4 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. NA Employee E5 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. NA Employee E6 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/32/25. NA Employee E7 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any other needs, and facility education provided on 10/23/25. NA Employee E8 confirmed the use of the white board when caring for residents to provide instruction for additional safety measures or any