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	06/25/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance during care to prevent accidents which resulted in actual harm of a nondisplaced nasal bone (nose) fracture for one of five residents (Resident R1). This was identified as harm for past non-compliance.Findings include: Review of the facility policy Fall Risk Assessment Policy dated 11/21/25, indicated it is the policy of Presbyterian Senior Care Network to provide a safe environment. Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Review of the admission record indicated that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/26, indicated a diagnoses of cerebral infarct (stroke), hemiplegia right dominant side (paralysis right side of body), osteoporosis (weak fragile bones), and depression. Section C0500 indicated a Brief Interview for Mental Status (BIMS- is a screening test that aids in detecting cognitive impairment) score of 6 - severely impaired cognition. Section GG - Functional Abilities - Mobility, Question GG0170R indicated the resident was coded at a 01 dependent. 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 R1's care plan initiated 5/10/23, indicated the resident has an ADL (activities of daily living) deficit related to limited mobility. Resident is at risk for falls related to right side hemiplegia. The care plan goal indicated the resident will be free of falls, free of minor injury, and will not sustain serious injury (related to falls). Further review of Resident R1's care plan indicated an assist of one for bed mobility.The facility utilizes a whiteboard in each resident room. This is updated every shift at a minimum. This mechanism is used for resident care to include bed mobility, transfer status, adaptive equipment use, etc. Review of Resident R1's clinical record nursing progress note dated 6/3/26, at 10:35 p.m., indicated; alerted to residents' room by floor nurse with resident on the ground. States that CNA was doing care and resident rolled out of bed. Abrasion noted on bridge of nose, starting to bruise and slowly seeping blood. abrasions and swelling noted to forehead and right eye appears to be red and bruising. resident states that he feels sore. Medical provider called, video appointment was completed and orders received to send to hospital for evaluation. Further review of Resident R1's clinical record nursing progress note dated 6/4/26, at 4:15 a.m., indicated the hospital emergency department contacted the facility nursing staff, informing the resident will be transferred to another hospital. Resident R1returned to the nursing home from the hospital on 6/4/26, with a diagnosis that included a hairline nondisplaced nasal bone fracture. Review of NA Employee E1's signed witness statement dated 6/4/26, indicated, after completing care on Resident R1, I left him on his side towards the middle of the bed facing the door. I stated to the resident I was grabbing his brief and removed my hand from his side. As I was turning back with the brief, Resident R1 rolled off the bed. I immediately called for help. Review of the facility provided occurrence report indicated, NA Employee E1 had Resident R1 on his side to change his brief when he rolled out of bed. Resident was an assist (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 0689 Level of Harm - Actual harm Residents Affected - Few	of one for bed mobility. Resident interventions in place at the time of the fall, wide bed with bolsters, call light in reach, and low bed. Fall risk reassessed. Interview on 6/25/26, at 2:35 p.m. with NA Employee E1 indicated Resident R1 was rolled away from her onto his right-side and she turned away from the resident to reach for the brief and cream to compete the resident's care. NA Employee E1 confirmed, at the time she removed her hand away from the resident, turned her back to the resident, and was picking up the brief and cream on the chair behind her, was the moment Resident R1 rolled out of bed onto the floor. Review of NA Employee E1's personnel file indicated a hire date of 7/28/25, and Employee E1 received nurse aide training and competencies in the ability to provide care and identify safety hazards methods per the care plan, assisting with transfers, and transferring residents safely, completed on 7/28/25 with the most recent review date of 3/26/26 by NA Employee E1. On 6/4/26, the facility-initiated education for all direct care nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides (NAs) indicating the facility must ensure that; The resident environment remains as free from accidents hazards as is possible.-Each resident receives adequate supervision and assistance devices to prevent accidents. -Abuse and neglect. -Resident Mobility and Transfers.-Proper Bed Mobility Techniques.-Transfer Safety. This plan includes the following: -Immediate suspension of NA Employee E1.-Facility completed a full house audit to identify other residents who could benefit from a wider bed and who may benefit from a therapy screen for bed mobility. -Ongoing audits will be completed for two months, for all falls out of bed to evaluate equipment and therapy bed mobility evaluation. -Education was completed on 6/18/26, to all nursing staff on accidents, abuse and neglect.-Audits and education were reviewed with the Quality Assurance and Performance Improvement Committee for trends and outcomes. During interviews on 6/25/26 from 10:00 a.m. to 2:50 p.m., the following was revealed: NA Employee E1 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. NA Employee E2 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. NA Employee E3 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs and completed the facility provided education. RN Employee E4 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. NA Employee E5 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. LPN Employee E6 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. NA Employee E7 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. RN Employee E8 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. LPN Employee E9 confirmed the use of the whiteboard when caring for residents to provide instruction for additional safety measures or any other needs, and completed the facility provided education. The facility has demonstrated compliance with the regulations since 6/18/26. During an interview on 6/25/26, at 3:00 p.m. with the Nursing Home Administrator and Director of Nursing, and review of the facility's immediate actions, education, and review of the QAPI monitoring process to sustain solutions, it was verified that the facility had implemented a plan of correction and achieved compliance for the prevention of resident injury. During an interview on 6/25/26, at approximately 3:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to make certain each resident received adequate supervision and assistance during care to prevent accidents which resulted in actual harm and was identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.