STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395682	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, resident records, resident interview and staff interviews, it was determined that the facility neglected to provide goods and services for one out of five sampled records (Resident R1). The deficiency is cited as past non-compliance. Findings include: The facility Resident abuse policy dated 7/2/25 and last reviewed 10/28/25, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents and misappropriation of resident property. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility General dose preparation and mediation administration policy dated 11/15/24 and last reviewed 10/28/25, indicated prior to administration of medication, facility staff should take all measures required by facility policy and applicable including the following: verify each time a medication is administered that it is the correction medication, at the correct dose, at the correct route, at the correct rate, and at the correct time for the correct resident. Review of Resident R1's admission record indicated he was originally admitted on [DATE]. Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/26/25, indicated he had diagnoses that included history of falls, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R1's care plans dated 1/30/25, and updated 12/17/25, indicated to administer medications as per Physician orders. Review of Resident R1's Medication Administration Record (MAR) for January 2026, indicated he did not receive the following medications on 1/6/26 during the 3-11 p.m. shift: Seroquel 150mg Atorvastatin 10mg at bedtime Lantus Solostar 28 units subcutaneous at bedtime Review of Resident R1's Medication Administration Record (MAR) notes for 1/6/26, indicated that each medication (Seroquel 150mg, Atorvastatin 10mg at bedtime, Lantus Solostar 28 units) were documented by Agency Registered Nurse (RN) Employee E1 as not administered/resident refused. Review of Resident R1's clinical progress notes dated 1/7/26, indicated that Resident R1 approached nursing staff and reported that he did not receive his scheduled medications for the 3-11 shift on 1/6/26. Facility investigation documents dated 1/7/26, indicated Resident R1 provided the following statement: around 7 p.m. on 1/6/26, Resident R1 was informed by Agency Registered Nurse (RN) Employee E1 that he was not permitted in kitchenette to retrieve snacks. Resident R1 went outside after he and Agency Registered Nurse (RN) Employee E1 argued. When he returned to his room around 10 p.m., Agency Registered Nurse (RN) Employee E1 saw him and did not provide his medications. Facility documentation and statements dated 1/7/26, indicated the following statement from RN Supervisor Employee E2: On the 1/6/26 3-11 shift, RN Supervisor Employee E2 worked with Agency RN Employee E1. During this shift, Agency RN Employee E1 was witnessed in a verbal altercation with Resident R1. RN Supervisor Employee (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E2 intervened. RN Supervisor Employee E2 offered to pass Resident R1 medications and Agency RN Employee E1 refused the assistance. Upon beginning the day shift on 1/6/26, Resident R1 informed staff that Agency RN employee E1 refused to provide bedtime medications. Facility investigation statement on 1/7/26 from Nurse Aide Employee E3 indicated that Agency Registered Nurse (RN) Employee E1 requested that another nurse or the RN Supervisor Employee E2 provide Resident R1 his medications because he was being very rude and calling her out of her name. Nurse staff refused to assist Agency RN Employee E1. Facility documentation dated 1/8/26, indicated the following statement from Agency Registered Nurse (RN) Employee E1: on 1/6/26, around 8:00 p.m. Resident R1 was seen in the resident kitchenette. Agency RN Employee E1 informed Resident R1 that he was not permitted in that area. An argument started. The RN Supervisor Employee E2 then intervened. Resident R1 then went and sat across the nurse station and was smirking and calling Agency RN Employee E1 the B-word. She gained access to the EMAR around 8:30 p.m. and the resident left the unit with a hoodie on. Agency RN Employee E1 was going to ask for the RN Supervisor Employee E2 or another nurse to provide Resident R1 with his medications when he returned or have a nurse come so the could witness him receiving his medications. Resident R1 did not return to the unit until 1:30 a.m. and did not request his medications. Review of Agency Registered Nurse (RN) Employee E1's personnel record indicated she was trained on abuse and neglect on 5/22/24. During an interview on 2/20/26, at 11:54 a.m. Resident R1 was asked about incident on 1/6/26 and stated the following: it was between 8 and 9 p.m. and she, the nurse, was not around. And I went into my room. She never came to give me my medications. I've seen other nurses since. I had no ill effects or nothing. When asked if Resident R1 left the facility until 1 a.m.? I did not step out until 1 a.m. On 1/6/26, the facility initiated the following plan of correction actions which included:1) Re-education on abuse with nursing staff starting 1/27/26.2) Re-education on transporting residents in wheelchairs with nursing staff.3) Audit of medication administration for 19 residents on the First floor starting 1/6/264) Three head-to-toe assessments on three residents starting 1/7/265) Termination of Agency Registered Nurse (RN) Employee E1 Review of education, audits and resident interviews on 2/20/26, indicated that the facility has demonstrated compliance with the regulation as of 1/27/26. During an interview on 2/20/26, at 1:47 p.m. information was disseminated to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) that the facility neglected to provide goods and services for Resident R1 as required and that the facility had implemented a plan of correction and achieved compliance on 1/27/26 after implementing corrective actions. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, facility documentation, resident interview, and staff interview, it was determined that the facility failed to make certain significant medications are administered as ordered by the physician for one of five sampled residents (Resident R1).Findings include: The facility General dose preparation and mediation administration policy dated 11/15/24 and last reviewed 10/28/25, indicated prior to administration of medication, facility staff should take all measures required by facility policy and applicable including the following: verify each time a medication is administered that it is the correction medication, at the correct dose, at the correct route, at the correct rate, and at the correct time for the correct resident. Review of Resident R1's admission record indicated he was originally admitted on [DATE]. Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/26/25, indicated he had diagnoses that included history of falls, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R1's care plans dated 1/30/25, and updated 12/17/25, indicated to administer medications as per Physician orders. Review of Resident R1's Medication Administration Record (MAR) for January 2026, indicated he did not receive the following medications on 1/6/26 during the 3-11 p.m. shift: Seroquel 150mg Atorvastatin 10mg at bedtime Lantus Solostar 28 units subcutaneous at bedtime Review of Resident R1's Medication Administration Record (MAR) notes for 1/6/26, indicated that each medication (Seroquel 150mg, Atorvastatin 10mg at bedtime, Lantus Solostar 28 units) were documented by Agency Registered Nurse (RN) Employee E1 as not administered/resident refused. Review of Resident R1's clinical progress notes dated 1/7/26, indicated that Resident R1 approached nursing staff and reported that he did not receive his scheduled medications for the 3-11 shift on 1/6/26. Facility investigation documents dated 1/7/26, indicated Resident R1 provided the following statement: around 7 p.m. on 1/6/26, Resident R1 was informed by Agency Registered Nurse (RN) Employee E1 that he was not permitted in kitchenette to retrieve snacks. Resident R1 went outside after he and Agency Registered Nurse (RN) Employee E1 argued. When he returned to his room around 10 p.m., Agency Registered Nurse (RN) Employee E1 saw him and did not provide his medications. Facility documentation and statements dated 1/7/26, indicated the following statement from RN Supervisor Employee E2: On the 1/6/26 3-11 shift, RN Supervisor Employee E2 worked with Agency RN Employee E1. During this shift, Agency RN Employee E1 was witnessed in a verbal altercation with Resident R1. RN Supervisor Employee E2 intervened. RN Supervisor Employee E2 offered to pass Resident R1 medications and Agency RN Employee E1 refused the assistance. Upon beginning the day shift on 1/6/26, Resident R1 informed staff that Agency RN employee E1 refused to provide bedtime medications. Facility investigation statement on 1/7/26 from Nurse Aide Employee E3 indicated that Agency Registered Nurse (RN) Employee E1 requested that another nurse or the RN Supervisor Employee E2 provide Resident R1 his medications because he was being very rude and calling her out of her name. Nurse staff refused to assist Agency RN Employee E1. Facility documentation dated 1/8/26, indicated the following statement from Agency Registered Nurse (RN) Employee E1: on 1/6/26, around 8:00 p.m. Resident R1 was seen in the resident kitchenette. Agency RN Employee E1 informed Resident R1 that he was not permitted in that area. An argument started. The RN Supervisor Employee E2 then intervened. Resident R1 then went and sat across the nurse station and was smirking and calling Agency RN Employee E1 the B-word. She gained access to the EMAR around 8:30 p.m. and the resident left the unit with a hoodie on. Agency RN Employee E1 was going to ask for the RN Supervisor Employee E2 or another nurse to provide Resident R1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with his medications when he returned or have a nurse come so they could witness him receiving his medications. Resident R1 did not return to the unit until 1:30 a.m. and did not request his medications. Review of Agency Registered Nurse (RN) Employee E1's personnel record indicated she was trained on abuse and neglect on 5/22/24. During an interview on 2/20/26, at 11:54 a.m. Resident R1 was asked about incident on 1/6/26 and stated the following: it was between 8 and 9 p.m. and she, the nurse, was not around. And I went into my room. She never came to give me my medications. I've seen other nurses since. I had no ill effects or nothing. When asked if Resident R1 left the facility until 1 a.m.? I did not step out until 1 a.m. During an interview on 2/20/26, at 1:47 p.m. information was disseminated to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) that the facility failed to make certain significant medications are administered as ordered for Resident R1 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28Pa. Code:211.9(e)(f)(g)(h) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies.