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	08/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation and staff interview, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for one of three residents (Resident R82).Findings include: Review of a booklet titled Know Your Rights as a Nursing Home Resident provided to residents upon admission to the facility indicated residents have the right to privacy and to be treated with dignity and respect. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. Review of Resident R82's [NAME] Data Set (MDS - a periodic assessment of care needs) dated 6/4/25, indicated diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Review of the facility provided pressure ulcer list indicated Resident R82 developed a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to their outer right ankle on 3/13/25. During an observation of wound care on 8/21/25, from 1:58 p.m., through 2:10 p.m., Licensed Practical Nurse (LPN) Employee E3 wrote on the dressing after it was placed on Resident R82's right outer ankle. During an interview on 8/21/25, at 2:11 p.m. LPN Employee E3 confirmed the facility failed to maintain Resident R82's dignity when writing on the dressing after placement on the resident. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.29(a) Resident rights.

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
	395682	A. Building B. Wing	08/22/2025

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of resident and staff interview it was determined that the facility failed to respond to resident concerns and grievances identified during resident council meeting. Findings include: Federal Regulation includes:S483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i)The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.(ii)Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.(iii)The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.(iv)The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.(A)The facility must be able to demonstrate their response and rationale for such response. Resident group meeting on 8/20/25, at 11:45 a.m. Residents indicated that they discuss the same concerns every meeting - specifically call bells, food and staffing. Resident indicated that they do not get feedback on their concerns. During an interview on 8/22/25, at 12:11 p.m. Activities Director Employee E22 confirmed that call bells, food and staffing are discussed every meeting, without resolution and the facility failed to respond to resident groups on-going concerns. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 201.18 (b) (1) Management.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, observations and staff interviews it was determined that the facility failed to identify a bolster (a long, thick cushion) as a possible restraint, and failed to assess the functional status of the individual resident to determine if the use of a bolster is a restraint for one of four residents (Resident R76).Findings include: Review of facility policy Restraint Policy dated 7/3/25, last dated 1/19/24, indicated physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use. Use the Enabler Restraint Observation to determine if the device restricts the resident's freedom of movement. Before proceeding with the device identified as a restraint, the interdisciplinary team evaluates factors leading to the consideration of the device, determines that all the resident's needs are being met and the need to restraint is not due to unmet needs, determines that all alternative measures have been attempted and found to be unsuccessful, weighs the risks versus benefits of the restraints being considered, involves resident and family in decision making and educates them regarding risks and benefits, analyzes all information and decides which devices is most appropriate, and develops measures to minimize risk and resident decline as a result of use. Physical Restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/29/25, indicated diagnoses of high blood pressure, muscle weakness, and other lack of coordination. During an observation on 8/18/25, at 10:33 a.m. Resident R76 was observed lying in bed with bolsters between her their body on both sides of the bed. Review of a physician order dated 11/29/23, indicated resident to use bilateral (both sides) bolsters while in bed as tolerated. Review of Resident R76's care plan dated 2/10/25, indicated the resident has a history of falling related to decreased safety awareness, alteration in cognition, and impulsivity. Interventions include keep bed in lowest position with brakes locked. Floor mat to door side of bed, contour mattress with bolsters overlay, bilateral foam wedges for positioning, every shift, as tolerated. Review of Resident R76's clinical record failed to identify any assessments or ongoing evaluations for the use of bolsters. During an interview on 8/22/25, at 11:36 a.m. information was disseminated to the Director of Nursing that the facility failed to assess Resident R76 for a restraint, and failed to have any ongoing evaluation of a possible restraint related to the use of bolsters. 28 Pa. Code: 211.8(e) Use of restraints.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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	395682	A. Building B. Wing	08/22/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interviews, it was determined that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication for two of three residents (Resident R8 and Resident R63).Findings include: Review of facility policy Psychoactive Medication Policy dated 7/3/25, indicated all residents receiving psychoactive medication(s) will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a gradual dose reduction of psychoactive medications monitored and documented. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/19/25, indicated diagnoses of left hip fracture, diabetes mellitus (group of diseases that affect how the body uses blood sugar (glucose)), and chronic kidney disease. Review of Resident R8's physician orders dated 1/10/25, indicated Lorazepam (antianxiety medication) tablet; 0.5 mg (milligram): amount: 1 tab; oral. Special instructions: give one tab every 8 hours, hold for sedation. Review of Resident R8's physician order dated 7/23/25, indicated Olanzapine (Zyprexa - antipsychotic medication) tablet; 10 mg; amount: 1 tab; oral. Special instructions: give between 6:00 - 8:00 p. m. Within the order, the associated diagnosis was not defined. Review of Resident R8's physician order 4/17/25, indicated Sertraline (antidepressant) tablet; 100 mg; amount: 1 tablet; oral. Once a day. Review of Resident R8's current care plan on 8/20/25, indicated approaches to psychotropic drug use were to administer medication as per physician orders, observe for effectiveness of drug treatment and side effects. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Notify MD if needed. Access/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Attempt non pharmacological interventions. Observe for effectiveness. Quantitatively and objectively document the resident's behavior. Review of Resident R8's clinical record failed to indicate any documented non-pharmacological interventions or effectiveness of pharmacological interventions; clinical record also failed to indicate evidence that the facility had implement side effect or behavior monitoring for psychotropic medication use. Review of the clinical record indicated Resident R63 was admitted to the facility on [DATE]. Review of Resident R63's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/3/25, indicated diagnoses of dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), history of falls, and dysphagia (difficulty swallowing solids and/or liquids). Review of Resident R63's physician order dated 2/28/25, indicated Alprazolam (Xanax - antianxiety medication) tablet; 0.5 mg; amount: 1 tab; oral. Special instructions: Hold for sedation. Twice a day. Review of Resident R63's physician order dated 2/14/25, indicated Alprazolam tablet; 1.0 mg; amount: 1 tab; oral. Special instructions: 30 minutes before shower on Tuesday and Friday. Once a day on Tuesday and Friday. Review of Resident R63's physician order dated 6/12/25, indicated Seroquel (antipsychotic) tablet: 25 mg; amount: 1 tab; oral. Once a day. Review of Resident R63's physician order dated 6/11/25, indicated Seroquel tablet; 50 mg; amount: 1 tab; oral. At bedtime. Review of Resident R63's current care plan on 8/20/25, indicated approaches to psychotropic drug use were to administer medication as per physician orders, observe for effectiveness of drug treatment and side effects. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Notify MD if needed. Access/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Monitor resident's behavior and response to medication. Quantitatively and objectively document the resident's behavior. Review of Resident R63's clinical record failed to indicate any documented non-pharmacological interventions or effectiveness of pharmacological interventions; clinical record also failed to indicate evidence that the facility had implement side effect or behavior monitoring for psychotropic medication use. During an interview on 8/21/25, at 9:25 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E18 confirmed that within Resident R8's antipsychotic medication's (Olanzapine) physician order failed to have a diagnosis, and confirmed that Resident R8 and R63 did not have proper clinical documentation reflective of psychotropic medication usage and monitoring, acknowledging that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication for two of three residents (Resident R8 and Resident R63). 28 Pa. Code 211.2(d)(3) Medical director28 Pa. Code 211.10(a) Resident care policies

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	395682	A. Building B. Wing	08/22/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documents, and staff interviews, it was determined that the facility failed to report an allegation of neglect within 24 hours to the local state field office for two of three residents (Resident R2 and Resident R33).Findings include: Review of facility policy Abuse, Neglect, and Exploitation dated 7/3/25, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of resident, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. Review of admission Record indicated Resident R2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of resident needs) dated 5/2/25, indicated diagnosis of epilepsy (also known as seizure disorders a brain condition that causes recurring seizures) and anxiety disorder (are a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) . During an interview on 5/18/25, with Resident R2 Family member indicated the following: Resident R2 has history of seizures, he had a grand mal seizure. Resident R2 was taken at the hospital where the family was told that he needed Keppra (an anti-epileptic drug - used to treat different types of seizures). Family discussed with the hospital that he should have been on Keppra consistently due to having seizures. The hospital informed the family that he was not on Keppra. The family indicated that Resident R2 went out to the hospital in April and was sent back with a 30-day order for Keppra. Resident R2 family Member informed the DON (Director of Nursing) of the incident. The family believes that the facility failed to continue the order for Keppra past the 30 days from April. Review of Resident R2 clinical record - physician orders for May (finished the 30-day order from April), June, July and August failed to include on-going Keppra as an order. Review of Resident R2 clinical record MAR's (medication administration record - a record that documents residents medication) review of May - showed the Keppra ending from the hospital order of Keppra for 30 days, with no on-going orders for Keppra for June July and August - until the resident was sent out to the hospital and returned with a new order for Keppra for 30 days. During an interview on 8/21/25, 11:13 a.m. DON (Director of Nursing) and ADON (Assistant Director of Nursing) confirmed that Resident R2 was on Keppra prior to be sent out in April, was sent out to the hospital and had an order for Keppra for 30 days, and the facility did not continue the Keppra and was unaware of the incident until Resident R2 Family member brought it to their attention on Monday and the facility failed to report the incident to the department within 24 hours. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of admission record for indicated Resident R33 was admitted to facility 5/31/24. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/1/25, indicated the diagnoses of dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), anxiety disorder, and hypothyroidism (underactive thyroid, occurs when the thyroid gland does not produce enough thyroid hormone). Review of Resident R33's clinical physician progress note dated 8/15/25, at 6:21 p.m., revealed Clinical concern: Medication given in error. This female (Resident R33) being seen after wrong medications were administered. She received Trazodone (antidepressant) 50 mg (milligrams), Senna (laxative) 8.2 mg, Zyprexa (antipsychotic) and Tramadol (opioid) 50 mg. No s/s (sign/symptoms) of any acute distress. She is A/O (alert/oriented) at baseline. VSS (vital signs stable). Condition is stable. Further review of Resident R33's clinical progress note dated 8/19/25, at 5:38 p.m., recorded as a late entry for 8/15/25 - medication error by Registered Nurse (RN) Employee E17 revealed on 8/15/25, during evening medication pass this resident (R33) was medicated with medications that were ordered for another resident. LPN (Licensed Practical Nurse) did call supervisor. This resident was not medicated with her routine HS (hour of sleep) medications on 8/15/25. Education provided to LPN on the checks to be made prior to administering medications. Resident did not exhibit any adverse effects from these medications. Review of documentation provided to the local state field office from 8/1/15, through 8/21/25, did not include Resident R33's incident of neglect. During an interview on 8/21/25, at 9:45 a.m., the Director of Nursing (DON) confirmed that the facility failed to report an allegation of neglect within 24 hours to the local state field office for one of three residents (Resident R33). 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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	395682	A. Building B. Wing	08/22/2025

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record reviews and staff interviews, it was determined that the facility failed to initiate a thorough investigation for allegations of neglect for two of three residents (Residents R2 and Resident R33). Findings include: Review of facility policy Abuse, Neglect, and Exploitation dated 7/3/25, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of resident, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. Review of admission record for Resident R2 indicated was admitted to the facility on [DATE] and re-admitted on [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of resident needs) dated 5/2/25, indicated diagnosis of epilepsy (also known as seizure disorders a brain condition that causes recurring seizures) and anxiety disorder (are a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) . During an interview on 5/18/25, with Resident R2 Family member indicated the following: Resident R2 has history of seizures, he had a grand mal seizure. Resident R2 was taken at the hospital where the family was told that he needed Keppra (an anti-epileptic drug - used to treat different types of seizures). Family discussed with the hospital that he should have been on Keppra consistently due to having seizures. The hospital informed the family that he was not on Keppra. The family indicated that Resident R2 went out to the hospital in April and was sent back with a 30-day order for Keppra. Resident R2 family Member informed the DON (Director of Nursing) of the incident. The family believes that the facility failed to continue the order for Keppra past the 30 days from April. Review of Resident R2 clinical record - physician orders for May (finished the 30-day order from April), June, July and August failed to include on-going Keppra as an order. Review of Resident R2 clinical record MAR's (medication administration record - a record that documents residents medication) review of May - showed the Keppra ending from the hospital order of Keppra for 30 days, with no on-going orders for Keppra for June July and August - until the resident was sent out to the hospital and returned with a new order for Keppra for 30 days. Review of Resident R2 facility investigation 8/21/25, failed to include: a summary of the investigation/findings, any witness statements, the discharge summary from 8/18/25, did not include a witness statement from the family member, or documentation stating how the medication error occurred, why it went on from May, June, July and August, and wasn't identified until the family member brought it to the facility's attention. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/25, 11:13 a.m. DON (Director of Nursing) and ADON (Assistant Director of Nursing) confirmed that Resident R2 was on Keppra prior to be sent out in April, was sent out to the hospital and had an order for Keppra for 30 days, and the facility did not continue the Keppra and was unaware of the issue until Resident R2 family member brought it to their attention. The DON and ADON were informed that the facility failed to do a thorough and complete investigation into the medication error for Resident R2. Review of admission record for indicated Resident R33 was admitted to facility 5/31/24. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/1/25, indicated the diagnoses of dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), anxiety disorder, and hypothyroidism (underactive thyroid, occurs when the thyroid gland does not produce enough thyroid hormone). Review of Resident R33's clinical physician progress note dated 8/15/25, at 6:21 p.m., revealed Clinical concern: Medication given in error. This female (Resident R33) being seen after wrong medications were administered. She received Trazodone (antidepressant) 50 mg (milligrams), Senna (laxative) 8.2 mg, Zyprexa (antipsychotic) and Tramadol (opioid) 50 mg. No s/s (sign/symptoms) of any acute distress. She is A/O (alert/oriented) at baseline. VSS (vital signs stable). Condition is stable. Further review of Resident R33's clinical progress note dated 8/19/25, at 5:38 p.m., recorded as a late entry for 8/15/25 - medication error by Registered Nurse (RN) Employee E17 revealed on 8/15/25, during evening medication pass this resident (R33) was medicated with medications that were ordered for another resident. LPN (Licensed Practical Nurse) did call supervisor. This resident was not medicated with her routine HS (hour of sleep) medications on 8/15/25. Education provided to LPN on the checks to be made prior to administering medications. Resident did not exhibit any adverse effects from these medications. Review of documentation provided by the facility on 8/20/25, at 9:30 a.m., revealed an incident report completed by RN Employee E17 identifying Resident R33, and that a medication error occurred on 8/15/25, at 6:24 p.m. Further review revealed no additional information about the event was documented on this report. Further review of documentation provided by the facility on 8/20/25, at 9:30 a.m., failed to reveal a witness statement by staff LPN responsible for medication error or Resident R33 interview; failed to identify whose medication were provided to Resident R33; failed to identify any other residents who may have also been provided incorrect medications; and failed to identify corrective action or root cause analysis as to why medication error occurred. During an interview on 8/21/25, at 9:45 a.m., the Director of Nursing (DON) confirmed that the facility failed to initiate a thorough investigation for allegations of neglect for one of three residents (Resident R33). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	395682	A. Building B. Wing	08/22/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of two residents sampled with facility-initiated transfers (Residents R4 and R114), and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of two resident hospital transfers (Residents R4, and R114).Findings include: Review of facility policy Resident Discharge/Transfer Letter Policy dated 7/3/25, and previously reviewed 1/19/24, indicated that the resident or responsible party will receive a bed hold notice along with the discharge/transfer letter. A copy of the completed bed hold notice will be scanned into the electronic chart and filed in business file with certified receipt attached if applicable, with copy of the discharge/transfer letter. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and depression. Review of the clinical record indicated Resident R4 was transferred to the hospital 3/1/25, and returned to the facility on 3/6/25. Review of Resident R4's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R4's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/1/25. Review of the clinical record indicated Resident R114 was admitted to the facility on [DATE]. Review of Resident R114's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), urinary tract infection, and chronic kidney disease. Review of the clinical record indicated Resident R114 was transferred to the hospital on 7/19/25, and returned to the facility on 7/23/25. (continued on next page)

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	08/22/2025

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R114's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R114's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/19/25. During an interview on 8/21/25, at 12:48 p.m. the Assistant Director of Nursing (ADON) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for Residents R4 and R114. During an interview on 8/21/25, at 1:31 p.m. Regional Operations Manager Employee E6 confirmed that the facility failed to notify the resident or resident representative of the facility bed-hold policy for Residents R4 and R114. 28 Pa. Code: 201.29 (a) (c.3) (2) Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for two of five residents (Residents R79 and R95).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:N0350, Insulin: enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and other lack of coordination. Question N0350A was coded 7 to indicate Resident R79 received insulin injections for seven days during the look-back period. Review of Resident R79's clinical record failed to include a physician order for insulin injections. Review of the clinical record indicated Resident R95 was admitted to the facility on [DATE]. Review of Resident R95's quarterly MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of a physician order dated 7/17/24, indicated to admit to hospice services routine level of care with terminal diagnosis of neurocognitive disorder with Lewy bodies (a type of dementia). Review of Resident R95's annual MDS dated [DATE], revealed that Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period. During an interview on 8/21/25, at 1:47 p.m. Registered Nurse Assessment Coordinator Employee E5 confirmed that the facility failed to ensure MDS assessments accurately reflected the resident's status for Residents R79 and R95. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.5(f) Medical records.

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	395682	A. Building B. Wing	08/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for six of 34 residents (Resident R3, Resident R8, Resident R55, Resident R63, Resident R148, and Resident R151).Findings include: Review of facility policy Comprehensive Care Planning dated 7/3/25, indicated an interdisciplinary plan of care will be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. The facility will develop comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. These plans will be focused on resident choice and abilities with the intact of maintaining or improving resident functional abilities and quality of life. The comprehensive care plan will be developed within seven (7) days after completion of the comprehensive assessment (MDS). Review of facility policy Dementia Care Service dated 7/3/25, indicated residents who are diagnosed with Alzheimer's/other forms of dementia or who display such symptoms will receive the appropriate treatment and services to attain or maintain his/her highest practicable physical/mental/psychosocial wellbeing. Staff will demonstrate the competencies and skills to support residents through the implementation of individualized approaches to care (including direct care and activities) that are focused on understanding, preventing, relieving and/or accommodating a resident's distress or loss of abilities. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/6/25, indicated diagnoses of dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), history of falls, and protein-calorie malnutrition. Review of Resident R3's clinical psychiatry progress note date 8/13/25, revealed past medical history of unspecified dementia. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's MDS dated [DATE], indicated diagnoses of vascular dementia (type of dementia caused by a reduced blood flow to the brain), diabetes mellitus (group of diseases that affect how the body uses blood sugar (glucose)), and chronic kidney disease. Review of Resident R8's clinical psychiatry progress note dated 8/6/25, revealed Chief complaint: Dementia/Depression/Agitation. Further review indicated a past medical history of dementia. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R3's, Resident R8's, and Resident R63's current plan of care on 8/21/25, failed to reveal comprehensive person-centered care plans for residents who are diagnosed with Alzheimer's/other forms of dementia or who display such symptoms, to include the appropriate treatment and services to attain or maintain his/her highest practicable physical/mental/psychosocial wellbeing. During an interview on 8/21/25, at 9:20 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E5 confirmed that the facility failed to develop care plans that included instructions to provide person centered care for three of 34 residents (Resident R3, Resident R8, and Resident R63) with diagnosis of dementia. Resident R55 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident R55 MDS (minimum data set a periodic assessment of resident needs) indicated diagnosis of depression. Review of Resident R55 clinical records indicated they were seen by psychiatry on 6/27/25, for anxiety disorder and depression (common and serious mental disorder that negatively affects how you feel, think, and act). Review of the clinical file indicated that Resident R55 saw psychiatry two additional times 7/14/25, and 8/4/25, for on-going psychotherapy issues with anxiety and depression. Review of the 8/4/25, psychotherapy notes indicated assessment and plan - please monitor for depressive symptoms or change in emotional living. Review of the care plans for Resident R55 failed to include any care plan for psychotherapy. During an interview on 8/22/25, at 3:56p.m. DON was informed that the facility failed to complete a care plan for Resident R55 on-going psychosocial concerns. Review of the clinical record indicated Resident R63 was admitted to the facility on [DATE]. Review of Resident R63's MDS dated [DATE], indicated diagnoses of dementia, history of falls, and dysphagia (difficulty swallowing solids and/or liquids). Review of Resident R63's clinical psychiatry progress note dated 8/6/25, revealed Chief complaint: Follow-up Dementia with agitation. Review of Resident R63's current plan of care on 8/21/25, failed to reveal comprehensive person-centered care plans for residents who are diagnosed with Alzheimer's/other forms of dementia or who display such symptoms, to include the appropriate treatment and services to attain or maintain his/her highest practicable physical/mental/psychosocial wellbeing. During an interview on 8/21/25, at 9:20 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E5 confirmed that the facility failed to develop care plans that included instructions to provide person centered care for three of 34 residents (Resident R3, Resident R8, and Resident R63) with diagnosis of dementia. Review of Resident R148’s indicated she was admitted on [DATE]. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R148’s MDS assessment dated [DATE], indicated she had diagnoses that included Alzheimer’s disease (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and diabetes (metabolic disorder impacting organ function related to glucose levels in the human body). Review of Resident R148’s physician orders dated 10/29/24, indicated to administer Humalog (insulin) subcutaneously with blood glucose monitoring, provide medication when meal is in front of resident, and provide insulin three times per the following protocol: 0-75= call doctor 76-150 = 0 units 151-200 = 3 units 201-250 =4 units 251-300 = 5 units 301-400 = 6 units 400-450 = 7 units if greater than 450= call MD, Physician Assistant, or Nurse Practitioner Review of Resident R148’s August Medication Administration Record (MAR) for 2025 indicated she was still receiving insulin for diabetes. Review of Resident R148’s care plans did not include the use of insulin and diabetes protocols related to hyperglycemia and hypoglycemia. During an interview on 8/21/25, at 1:25 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E18 confirmed that the facility failed to develop care plans that included the use of insulin and diabetes protocols related to hyperglycemia and hypoglycemia. Review of Resident R151’s admission record indicated he was admitted on [DATE]. Review of Resident R151’s MDS assessment dated [DATE], indicated that he had diagnoses that included chronic kidney disease, hypertension, and neurocognitive disorder with Lewy bodies (a condition characterized by protein deposits in the brain leading to cognitive decline, memory disorders, personality changes, and impaired reasoning). Review of Resident R151’s physician orders dated 8/6/25, indicated he was ordered Seroquel 25 mg once a day as needed due to the diagnoses of neurocognitive disorder with Lewy bodies. (continued on next page)

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	08/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R151’s progress note dated 7/21/25, indicated a nurse aide informed staff that Resident R151 was verbally aggressive, getting into another resident's face (female) and accusing her of stealing. Review of Resident R151’s care plans dated 6/12/25 to 8/17/25, did not include the resident’s neurocognitive decline disorder, behavioral issues related to cognitive disorders, or behavior interventions to assist Resident R151. During an interview on 8/22/25, at 11:36 a.m. information was disseminated to the Director of Nursing (DON) that the facility failed to develop care plans that included Resident R151’s cognitive disorder, behavioral issues and pertinent behavioral interventions. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(5) Nursing Services.

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	395682	A. Building B. Wing	08/22/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, staff interviews, and review of facility activities calendars, it was determined that the facility failed to provide sufficient activities to meet their interests and support the physical, mental, and psychosocial well-being of each resident on two out of five days observed on the Third Floor Memory Impaired unit (8/18/25 and 8/19/25).Based on facility policy, observations, review of facility activities calendars, and staff interviews, it was determined that the facility failed to provide sufficient activities to meet the interests of resident on two out five days observed on the Third Floor Memory impaired unit (8/18/25 and 8/19/25). Findings include: The facility Life enrichment program policy dated 5/4/23, last reviewed 7/3/25, indicated that an ongoing resident-centered life program, based on comprehensive assessments and care plans. The program will be designed to meet the interest (hobbies, cultural preferences) and the abilities of each resident. Programs will be scheduled and offered seven days a week, including evenings and weekends.During observations on 8/18/25, at 2:01 p.m. the Third floor common area was found with seven residents (Residents R155, R148, R100, R71, R37, R111, and Resident R94). The Activity calendar was posted and the scheduled activity stated, Silly songs. Observations found no activities taking place involving singing.During observations on 8/19/25, at 10:07 a.m. the Third floor common area was observed with no activities taking place. Ten residents were observed at that time in the common area (Resident R66, R137, R138, R155, R148, R100, R71, R37, R111, and Resident R94). The Activity calendar was posted and the scheduled activity stated, movement group.During observations on 8/19/25, at 2:05 p.m. the Third floor common area was observed with no activities taking place. Ten residents were observed at that time in the common area (Resident R66, R137, R138, R155, R148, R100, R71, R37, R111, and Resident R94). The Activity calendar was posted and the scheduled activity stated, crafts.During an interview on 8/19/25, at 2:07 p.m. interview with Nurse aide Employee E23 stated: the calendar may be wrong. They have music activity arriving at 3:00 p.m.During an interview on 8/19/25, at 2:23 p.m. the Activity Director Employee E22 stated: the crafts activity may have changed. When there is one activity person, she does the activity later. When asked if there is enough activity staff, Activity Director Employee E22 stated: no we are short on activity staff. During an interview on 8/20/25, at 1:08 p.m. information was disseminated to the Nursing Home Administrator (NHA) that the facility failed to provide sufficient activities to meet the interests of residents on the Third floor for two days. 28 Pa. Code: 211.10(d) Resident care policies.

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	395682	A. Building B. Wing	08/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **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 notify physicians of abnormal Capillary Blood Glucose (CBG) readings as per physician's order for one of three sampled residents (Residents R148) and failed to provide comprehensive skin assessments and provide appropriate care and treatment for two of five residents (Resident R31 and Residents R38) reviewed with skin condition concerns and failed to follow physician orders for vitals for one of five resident (Resident R2). Findings include: § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices. Review of facility policy Skin and Wound Care Best Practices dated 7/3/25, indicated the purpose is to provide evidence based preventative skin care and wound treatment to prevent unavoidable skin complications. Review of facility policy Pressure Injury Prevention and Treatment Policy darted 7/3/25, indicated that residents will be assessed for pressure injury risk on admission, quarterly, and with significant change in condition using the Braden Scale for Predicting Pressure Ulcer Risk. Pressure injuries identified will be assessed initially and at least weekly thereafter, until closed. Other wound types will be assessed every shift to determine presence of any ordered dressings and wound characteristics if observable. All assessments will include the following elements: - Location and stage *if pressure injury); - Size, depth and the presence, location and extent of any undermining or tunneling/sinus tract; - Exudate, if present: type, color, odor and appropriate amount; - Pain, if present: nature and frequency - Wound bed: color and type of tissue/character including evidence of healing as appropriate; - Appearance of surrounding tissue; - Any evidence of infection. The facility Hypoglycemia” policy dated 3/12/24, last reviewed 7/3/25, indicated that nursing g personnel are responsible for recognizing signs and symptoms of hypoglycemia (low blood sugar) and responding accordingly. Treatment of hypoglycemia will be at the direction of the attending provider. (continued on next page)

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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues, and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of admission record for Resident R2 indicated was admitted to the facility on [DATE], and re-admitted on [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of resident needs) dated 5/2/25, indicated diagnosis of epilepsy (also known as seizure disorders a brain condition that causes recurring seizures) and anxiety disorder (are a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) . During an interview on 5/18/25, with Resident R2 Family member indicated the following: Resident R2 has history of seizures, he had a grand mal seizure. Resident R2 was taken at the hospital where the family was told that he needed Keppra (an anti-epileptic drug - used to treat different types of seizures). Family discussed with the hospital that he should have been on Keppra consistently due to having seizures. The hospital informed the family that he was not on Keppra. The family indicated that Resident R2 went out to the hospital in April and was sent back with a 30 day order for Keppra. Resident R2 family Member informed the DON (Director of Nursing) of the incident. The family believes that the facility failed to continue the order for Keppra past the 30 days from April. Review of Resident R2 clinical record - physician orders for May (finished the 30 day order from April), June, July and August failed to include on-going Keppra as an order. Review of Resident R2 clinical record after discharge instructions from the hospital indicated residents vitals were to take place q 4 hours. Review of Resident R2 clinical record vitals failed to include vitals completed q4 hours. During an interview on 8/21/25, 11:13 a.m. DON (Director of Nursing) and ADON (Assistant Director of Nursing) were informed that the facility failed to follow the hospital discharge orders failed to include a reason why the orders should not be followed and did not complete Resident R2 vitals q 4 hours as ordered. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R31 admission sheet indicated they were admitted on [DATE], and re-admitted on [DATE]. Resident R31 MDS (minimum data set a periodic assessment of resident needs) dated 4/16/25, indicated diagnosis of unspecified protein - calorie malnutrition (condition caused by not getting enough calories or the right amount of key nutrients) , and unspecified dementia (group of symptoms affecting memory, thinking and social abilities). Review of Resident R31 clinical record progress notes dated 8/17/25, wound consultant saw Resident R31 and placed a dressing on skin wounds. Review of Resident R31 clinical record failed to include any further information on the skin wound until 8/21/25, when the wound consultant indicates that the dressing had not been changed, since 8/17/25, when they placed it on the resident and the wound sized increase. During an interview on 8/22/25, at approximately 10:15 a.m. Wound nurse LPN Employee E24 indicated the following: that Resident R31 had wounds and needed dressing, was given a dressing but wound need it to be changed as needed, the wound when they came back on 8/21/25, should have been changed prior to 8/22/25, an no documentation was noted in the clinical record of any nurse other than the wound consultant addressing the wound. During an interview on 8/22/25, at 11:23 a.m. DON (Director of Nursing) and ADON (Assistant Director of Nursing) confirmed that Resident R31 had wounds on their right lower extremity that had dressings applied on 8/17/25, and were not looked at until 8/21/25, by the wound nurse, the wounds did increase in size and got worse. The DON and ADON were informed that the facility failed to provide quality of care for Resident R31 with wounds. Review of admission record indicated Resident R38 was admitted to facility 12/26/23. Review of Resident R38's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/30/25, indicated the diagnoses dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), history of falls, and weakness. Review of Resident R38's current care plan revealed that resident is at risk for pressure ulcers. Review of Resident R38's clinical record revealed that a Braden Scale for Predicting Pressure Ulcer Risk assessment had not be completed since January 2024. Review of Resident R38's clinical progress note dated 7/4/25, at 1:56 p.m., revealed that resident has a line of red fluid filled blisters on left upper buttocks. Review of Resident R38's Point of Care History documentation (area of clinical record documentation by Nurse Aides care every shift) from 7/1/25, through 8/21/2025, failed to indicate any skin problem for the resident. (continued on next page)

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	08/22/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record failed to reveal a comprehensive skin assessment and/or care and treatment provided to left upper buttocks of Resident R38. Clinical record also failed to indicate that appropriate parties were notified of fluid filled blisters on left upper buttocks found 7/4/25. During an interview on 8/21/25, at 1:10 p.m., the Director of Nursing (DON) confirmed that the facility failed to provide a comprehensive skin assessment and provide appropriate care and treatment for Residents R38's skin condition concern found 7/3/25. Review of Resident R148’s indicated she was admitted on [DATE]. Review of Resident R148’s MDS assessment dated [DATE], indicated she had diagnoses that included Alzheimer’s disease (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and diabetes (metabolic disorder impacting organ function related to glucose levels in the human body). Review of Resident R148’s physician orders dated 10/29/24, indicated to administer Humalog (insulin) subcutaneously with blood glucose monitoring, provide medication when meal is in front of resident, and provide insulin three times per the following protocol: 0-75= call doctor 76-150 = 0 units 151-200 = 3 units 201-250 =4 units 251-300 = 5 units 301-400 = 6 units 400-450 = 7 units if greater than 450= call MD, Physician Assistant, or Nurse Practitioner Review of Resident R148’s August Medication Administration Record (MAR) for 2025 indicated she was still receiving insulin for diabetes. Review of Resident R148's vital records from October 2024 to August 2025, indicated the following Capillary Blood Glucose (CBG) readings: 10/26/24= 462 mg/dl 11/27/24= 460 mg/dl 8/16/25= 70 mg/dl (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R148's clinical records and physician documents did not include notifications to the physician as ordered related to the abnormal blood glucose levels on 10/26/24, 11/27/24, and 8/16/25. Review of Resident R148's clinical records, nurse notes and physician documents did not include interventions for the 8/16/25 hypoglycemia reading. During an interview on 8/20/25, at 10:37 a.m. License Practical Nurse (LPN) Employee E1 was asked about order for hypoglycemia and actions to take: “most of the residents have orders for hypoglycemia. ” She was asked when to notify a doctor: “usually it’s in the order. Notify if symptomatic and give prn (as needed). You have to check the sugar first. For Lantus (insulin), we would get a hold of a doctor if they were hyperglycemic. After hours, we have a video chat service.” During an interview on 8/20/25, at 10:45 a.m. Registered Nurse (RN) Employee E20 was asked about hypoglycemia orders and she stated: “yes. They are on record.” She was asked actions if glucose is to high: “a nurse rechecks the glucose and calls the physician. There should be an order there depending on what the glucose level reads.” During an interview on 8/20/25, at 1:08 p.m. information disseminated to the Nursing Home Administrator (NHA) that the facility failed to notify physicians of abnormal Capillary Blood Glucose (CBG) readings as per physician's order for Resident R148 as required. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 201.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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	08/22/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of facility documentation, review of clinical records, and staff interview, it was determined that the facility failed to identify and assess a resident for smoking safety in a timely manner for two of two residents (Residents R79 and R98), failed to reassess a resident after an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge), and failed to develop a comprehensive care plan with interventions to address the potential for elopement for one of three residents (Resident R110).Findings include: Review of the facility policy Resident Smoking Policy dated 7/3/25, and previously dated 1/19/24, indicated that during the admission process, nursing will ask residents if they smoke or have a desire/intent to smoke while in the facility. Anyone answering yes is further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The assessment is completed thereafter on readmission, quarterly, and with significant change in the resident's condition. Review of facility policy Elopement/Unauthorized Absence dated 7/3/25, previously dated 1/19/24, indicated the facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. All residents will be assessed for the risk of elopement using the Elopement Observation on admission, quarterly, and as needed. Residents identified at risk will have interventions promptly implemented to reduce the risk of elopement. Residents identified at risk will have their picture and face sheet or demographic form placed in a binder that is kept in an area accessible by staff. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (“BIMS”) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Facility provided a list of current smokers at the facility at survey entrance. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/29/25, indicated diagnoses of high blood pressure, muscle weakness, and other lack of coordination. Review of the facility provided list of current smokers did reveal Resident R79 as a smoker. Review of Resident R79's clinical record revealed an Admission/readmission Observation dated 7/22/25. The observation did not identify Resident R79 as a smoker. Review of Resident R79's clinical record did not reveal a completed Smoking Risk Assessment. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R79's current comprehensive care plan failed to include goals and interventions related to safe smoking. During an interview on 8/18/25, at 12:42 p.m. Resident R79 was observed smoking in the facility designated smoking area. Resident R79 stated, I come out to smoke when they [facility staff] can push me out in my chair. During an interview on 8/21/25, at 9:37 a.m. the Director of Nursing (DON) was disseminated information that the facility failed to identify and assess Resident R79 for smoking safety in a timely manner and failed to develop a comprehensive care plan for safe smoking. Review of clinical record revealed that Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, nicotine dependence (an addiction to tobacco products), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). During an interview on 8/19/25, at 9:39 a.m. Nurse Aide (NA) Employee E7 was asked to identify any residents who smoke on her unit. NA Employee E7 stated that Resident R98 smoked daily. Review of the facility provided list of current smokers did not reveal Resident R98 as a smoker. Review of Resident R98's clinical record revealed a Smoking Risk assessment dated [DATE], that identified Resident R98 as a safe smoker. Further review of Resident R98's clinical record failed to include a Smoking Risk Assessments completed after 2/18/24. During an interview on 8/21/25, at 9:34 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E5 confirmed that the facility failed to implement quarterly Smoking Risk Assessments after 2/18/24, as required. During an interview on 8/21/25, at 9:43 a.m. the DON was presented with the above information and confirmed that the facility failed to identify Resident R98 as a smoker, and failed to implement quarterly Smoking Risk Assessments on an ongoing basis. Review of the clinical record indicated Resident R110 was admitted to the facility on [DATE]. Review of Resident R110's MDS dated [DATE], indicated diagnoses of high blood pressure, End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood), and muscle weakness. Question C0500 BIMS Summary Score indicated the resident scored a 15, cognitively intact. Review of Resident R110's clinical record revealed an Admission/readmission Observation dated 7/29/25. The resident was not identified as at risk for elopement. (continued on next page)

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	08/22/2025

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Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note dated 8/2/25, stated, Pt (patient) found outside on her motorized scooter and residents from this facility told the nurse that was outside, that she had left. That nurse came and got me as she could not get a hold of the supervisor, she was on another call. One of the employees went up and brought the resident back in. Pt told the supervisor and myself that the OT (Occupational Therapist) told her if she signed a paper and had the staff informed that she was going out that it was ok. Education provided to this pt about this because this doesn't mean that she can ride around the neighborhood in her scooter unattended that we are liable for her as long as she is a resident here. Furthermore she did not sign a paper nor did any of the staff including me know of any such plans. Will continue to monitor as I am not sure she will be compliant as she has been non-compliant with just about everything since she has been admitted . Review of a physician order dated 8/3/25, indicated the resident has a safety/wanderguard (a wearable electronic monitoring device) and to check bracelet placement every shift (wheelchair). Review of Resident R110's care plan dated 8/18/25, indicated Resident R110 displays the following behaviors: rejection of care and wandering. The care plan failed to include interventions related to Resident R110's wanderguard or address the potential for elopement. Review of Resident R110's clinical record failed to reveal that an elopement re-assessment had been completed after the resident was found outside on 8/2/25. During an interview on 8/18/25, at 12:32 p.m. Licensed Practical Nurse (LPN) Employee E21 stated, Resident R110 has a wanderguard. She is alert and oriented, I think she just took her powerchair out one day and left the building. I'm not sure if she knew she couldn't leave on her own. She does go out with family now and has been good about letting staff know when she's leaving. Her wanderguard is on her power wheelchair. During an interview on 8/19/25, at 9:56 a.m. Resident R110 stated, They [facility staff] didn't tell me I wasn't allowed to leave the building on my own. I know that now. During an observation on 8/19/25, at 10:00 a.m. of the Elopement Binder located at the 1B Nurses Station failed to include Resident R110's picture or demographic form. During an interview on 8/22/25, at 11:36 a.m. information was disseminated to the DON that the facility failed to reassess Resident R110 after an elopement, failed to develop a comprehensive care plan with interventions to address the potential for elopement, and failed to timely update an elopement binder to include Resident R110. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395682	A. Building B. Wing	08/22/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to individualize care plans to address the resident specific nutritional concerns for two of six residents (Resident R10, and R76) and, failed to properly monitor weight and nutrition status by failing to obtain weights for one of three residents (Residents R10). Findings include: Review of the facility, Resident Weight Policy dated 7/3/25, and previously dated 1/19/24, indicated that weights will be obtained routinely in order to monitor nutritional health over time. Each resident's weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission, and monthly or more often if risk is identified, or as ordered. Review of facility policy Comprehensive Care Planning dated 7/3/25, previously dated 1/19/24, indicated the care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment in accordance with Resident Assessment Instrument (RAI) requirements. Review of Resident R10's admission record indicated she was initially admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS- periodic assessment of care needs) assessment dated [DATE], included diagnoses of anemia (too little iron in the body causing fatigue), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Section K0100 indicated that resident had loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing of choking during meals or when swallowing medications, and complaints of difficulty or pain with swallowing. Section K0300 indicated that resident had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician-prescribed weight loss program. Review of Resident R10's current plan of care, failed to reveal goals or interventions related to dysphagia. Review of Resident R10's weight record from 1/9/25, through 8/20/25, revealed the following: 1/9/25: 146 pounds 4/3/25: 130.9 pounds 4/8/25: 114.7 pounds 5/7/25: 112 pounds 7/8/25 114.5 pounds 8/6/25 104.6 pounds (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R10's clinical record failed to include documentation that weight was obtained in February 2025, March 2025, or June 2025. During an interview on 8/20/25, at 2:23 p.m. Registered Dietitian (RD) Employee E13 confirmed that the facility failed to include dysphagia interventions in plan of care, and failed to properly monitor weight and nutrition status by failing to obtain weights for Resident R10. Review of the clinical record indicated Resident R76 was admitted to the facility on [DATE].Review of Resident R76's MDS dated [DATE], indicated diagnoses of Traumatic Brain Injury (TBI - a disruption in the normal function of the brain), hemiplegia (paralysis on one side of the body) unspecified affecting right dominant side, and anxiety. Review of a physician order dated 1/29/25, indicated to administer free water 200 mL (milliliters) Q6hr (every six hours) 4 times per day. Administer 200 mL 4x/day to equal 800 mL/day. Review of Resident R76's current care plan indicated the resident requires enteral feeding (a method of providing nutrition directly into the gastrointestinal tract, typically through a feeding tube) related to dysphagia following TBI. Interventions included flush 175 mL H20 (water) q4hrs (every four hours) to total 1050 mL/d (milliliters per day) via PEG (a tube inserted in the stomach through the abdomen used to provide enteral nutrition and medications) every 6 hours. During an interview on 8/22/25, at 11:36 a.m. information was disseminated to the Director of Nursing that the facility failed to update and individualize Resident R76's care plan to reflect the resident's specific nutritional concerns. 28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (a machine that filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of two residents (Resident R110), and failed to develop a comprehensive person-centered care plan to address resident needs for one of two residents (Resident R110).Findings include: Review of facility policy Hemodialysis Care dated 7/3/25, previously dated 1/19/24, indicated communication between the dialysis provider and facility staff will occur before and after each hemodialysis treatment and as needed. Review of the clinical record indicated Resident R110 was admitted to the facility on [DATE]. Review of Resident R110's MDS dated [DATE], indicated diagnoses of high blood pressure, End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood), and muscle weakness. Review of a physician order dated 7/29/25, indicated the resident receives dialysis every Monday, Wednesday, and Friday. The order failed to include information regarding the dialysis center name, address, phone number, or scheduled chair time. Review of Resident R110's clinical record did not include complete communication forms for seven days during the period of 7/29/25, through 8/19/25. The incomplete forms were on the following dates: 7/30/25, 8/4/25, and 8/18/25. One communication form did not have a date written on it and no communication forms were located for 8/1/25, 8/8/25, and 8/13/25. Review of Resident R110's care plan dated 8/18/25, indicated the resident receives dialysis treatments. The care plan failed include Resident R110's scheduled dialysis days and dialysis facility information.During an interview on 8/20/25, at 2:15 p.m. information was disseminated to the Director of Nursing that the facility failed to provide consistent and complete communication with the dialysis center and failed to develop a comprehensive person-centered care plan to address resident needs for Resident R110. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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	395682	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for three of three residents (Residents R4, R54, and R95).Findings include: Review of facility policy Bed Rail dated 7/3/25, and previously dated 1/19/24, indicated if a bed or side rail or bar is used, the facility will evaluate the potential risks associated with the use of bed rails including entrapment, prior to bed rail installation using the Bed and Bed Rail Safety Inspection Checklist. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and depression. During an observation on 8/18/25, at 10:49 a.m. two top enabler bars were present on Resident R4's bed. Review of Resident R4's active physician orders on 8/19/25, failed to reveal an order for enabler bar usage. Review of Resident R4's clinical record on 8/19/25, failed to include an ongoing assessment for the resident's enabler bar usage, and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. Review of the clinical record indicated Resident R54 was admitted to the facility on [DATE].Review of Resident R54's MDS dated [DATE], indicated diagnoses of cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue), high blood pressure, and anxiety. Review of a physician order dated 6/29/23, indicated bilateral (both sides) assistive handrail to aide with positioning. Check placement every shift. Review of Resident R54's clinical record on 8/19/25, failed to include an ongoing assessment for the resident's enabler bar usage, and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. Review of the clinical record indicated Resident R95 was admitted to the facility on [DATE].Review of Resident R95's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of a physician order dated 6/28/23, indicated the resident has an electric bed, pressure redistribution mattress, with bilateral assistive handrails. Review of Resident R95's clinical record on 8/19/25, failed to include an ongoing assessment for the resident's enabler bar usage, and failed to include the development of goals and interventions related to the resident's enable bar usage in the care plan. During an interview on 8/22/25, at 9:50 a.m. information was disseminated to the Director that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for three of three residents as required. 28 Pa. Code: 201. 14 (a) Responsibility of licensee.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(5) Nursing services.

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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 and clinical records, family and staff interviews it was determined that the facility failed to make certain that residents are free of significant medication errors for two of two residents (Resident R2 and Resident R33). Findings include: Review of facility policy General Dose Preparation and Mediation Administration, dated 7/3/25, indicated prior to the administration of medication, facility staff should take all measures required, including, but not limited to the following: - verify each time a medication is administered that it is the correct mediation, at the correct dose, at the correct route, at the correct rate, and the correct time, for the correct resident, - confirm that the MAR (medication administration record) reflects the most recent medication order, - Check the expiration date of the mediation, - Check for allergies to the medication; and - if necessary, obtain vital signs. During medication administration, facility staff should take all measures required including, but not limited to the following: - verify resident identification per facility policy (e.g., picture, armband, name). - Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record (MAR). - Administer medication within timeframes specified by facility policy and manufacturer's information. Review of admission record indicated Resident R2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of resident needs) dated 5/2/25, indicated diagnosis of epilepsy (also known as seizure disorders a brain condition that causes recurring seizures) and anxiety disorder (are a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) . (continued on next page)

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	08/22/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/18/25, with Resident R2 Family member indicated the following: Resident R2 has history of seizures, he had a grand mal seizure on 8/18/25. Resident R2 was taken to the hospital where the family was told that he needed Keppra (an anti-epileptic drug - used to treat different types of seizures). Family discussed with the hospital that he should have been on Keppra consistently due to having seizures. The hospital informed the family that he was not on Keppra. The family indicated that Resident R2 went out to the hospital in April and was sent back with a 30-day order for Keppra. Resident R2 family member expressed concerns that after the hospital visit in April and after the 30-day order from April to May the facility failed to re-order Keppra , and they believe the Resident has not been on Keppra since that 30-day order ended (May 2025).Resident R2 family Member informed the DON (Director of Nursing) of the incident. The family believes that the facility failed to continue the order for Keppra past the 30 days from April till August when he received it in the hospital. Review of Resident R2 clinical record - physician orders indicated the following: Keppra (levetiracetam tablet; 500mg; amount: 1 tablet; Oral Special Instructions: Give 1 tablet by mouth twice a daily for seizure activity dated 3/30/2025 thru 4/16/2025. Keppra (levetiracetam tablet; 500mg; amount: 1 tablet; Oral Special Instructions: Give 1 tablet by mouth twice a daily for seizure activity dated 4/17/2025 thru 4/17/2025. Keppra (levetiracetam tablet; 500mg; amount: 1 tablet; Oral Special Instructions: Give 1 tablet by mouth twice a daily for seizure activity dated 4/17/2025 thru 5/16/2025. Keppra (levetiracetam tablet; 500mg; amount: 1 tablet; Oral Special Instructions: Give 1 tablet by mouth twice a daily for seizure activity dated 8/18/2025 thru 9/ 18/2025. Review of MAR (medication administration record - records medications given to residents) for May, June, July and August of 2025 failed to indicate Keppra was given from May 16, 2025, until 8/18/25 when Resident R2 returned from the hospital. Review of the hospital documents indicated seizure adults, indicated clinical impression - breakthrough seizure. During an interview on 8/21/25, 11:13 a.m. DON (Director of Nursing) and ADON (Assistant Director of Nursing) confirmed that Resident R2 was on Keppra prior to be sent out in April, had an order for Keppra for 30 days, and the facility did not continue the Keppra after the 30 days and was unaware of Resident R2 not being on Keppra as previously ordered. DON and ADON confirmed that they did not become aware of the issue until Resident R2 family member brought it to their attention. They confirmed that Resident R2 should have been on the Keppra as previously ordered or a physician note should have been documented explaining why the Resident was not on the medication. DON and ADON confirmed that the facility failed to give significant medication as needed and this resulted in a significant medication error leading to Resident R2 being sent to the hospital. Review of admission record indicated Resident R33 was admitted to facility 5/31/24. (continued on next page)

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	08/22/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/1/25, indicated the diagnoses of dementia (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities), anxiety disorder, and hypothyroidism (underactive thyroid, occurs when the thyroid gland does not produce enough thyroid hormone). Review of Resident R33's clinical physician progress note dated 8/15/25, at 6:21 p.m., revealed Clinical concern: Medication given in error. This female (Resident R33) being seen after wrong medications were administered. She received Trazodone (antidepressant) 50 mg (milligrams), Senna (laxative) 8.2 mg, Zyprexa (antipsychotic) and Tramadol (opioid) 50 mg. No s/s (sign/symptoms) of any acute distress. She is A/O (alert/oriented) at baseline. VSS (vital signs stable). Condition is stable. Further review of Resident R33's clinical progress note dated 8/19/25, at 5:38 p.m., recorded as a late entry for 8/15/25 - medication error by Registered Nurse (RN) Employee E17 revealed on 8/15/25, during evening medication pass this resident (R33) was medicated with medications that were ordered for another resident. LPN (Licensed Practical Nurse) did call supervisor. This resident was not medicated with her routine HS (hour of sleep) medications on 8/15/25. Education provided to LPN on the checks to be made prior to administering medications. Resident did not exhibit any adverse effects from these medications. During an interview on 8/21/25, at 9:45 a.m., the Director of Nursing (DON) confirmed that the facility failed to make certain that residents are free of significant medication errors for two of two residents (Resident R2 and Resident R33). 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.

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	08/22/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in three of three medications rooms (2A,), and one of four medication carts (3A Medication Cart).Findings include: Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 7/3/25, and previously dated 1/19/24, indicated that the facility should ensure that only authorized facility staff should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Facility should ensure medications and biologicals that 1) have an expired date on the label; 2) have been retained longer than recommended by manufacturer or supplier guidelines; or 3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e. vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Facility should ensure the medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges and manufacturer guidance. Refrigeration: 36-46 degrees Fahrenheit (F). During an observation on 8/19/25, at 1:42 p.m. on 2B Nurses Station medication storage cabinet, a bottle of stool softener was observed with an expiration date of December 2024, and a bottle of niacin (a B-vitamin) was observed with an expiration date of 7/19/25. During an observation on 8/19/25, at 1:46 p.m. on 2B Nurses Station the medication refrigerator was observed to be unlocked and the thermometer stated that the refrigerator was 50 degrees F. During an interview on 8/19/25, at 1:46 p.m. Licensed Practical Nurse (LPN) Employee E11 confirmed that the facility failed to remove expired medications, failed to ensure that the refrigerator was locked, and failed to ensure that the refrigerator was in acceptable range. During an interview on 8/19/25, at 2:01 p.m. Unit Manager Employee E15 confirmed that the facility also failed to maintain temperature logs for the 2B medication refrigerator during July and August 2025. During observations on 8/19/25, at 2:08 p.m. the Third floor Medication room was observed with LPN Employee E19, and the following was found: (continued on next page)

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	08/22/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-observations of the temperature log for the medication room refrigerator was found with four days without temperatures (8/4/25, 8/5/25, 8/6/25, and 8/18/25). During an interview on 8/19/25, at 2:34 p.m. information was disseminated to Director of Nursing (DON) that Third floor Medication room refrigerator was missing temperatures and the facility failed to ensure medications are stored and monitored at appropriate temperatures. During an observation and interview on 8/20/25, 10:46 a.m. on 2A Medication Room, Registered Nurse (RN) Employee E16 confirmed that the medication refrigerator was noted to be at 28 degrees F. During an observation on 8/20/25, at 9:35 a.m. of the 3A Medication Cart revealed the following outdated medications and medications not dated upon opening: Resident R8's Lantus insulin pen (a prefilled pen to inject long-acting insulin under the skin), open date 7/8/25, expiration date 8/5/25. Resident R123's [NAME] pen, open date 7/8/25, expiration date 8/5/25. Resident R152's Lantus pen, no open date. During an interview on 8/20/25, at 9:36 a.m. LPN Employee E1 confirmed the above observations and that the facility failed to properly store medications in the 3A Medication Cart. 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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	08/22/2025

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of three residents (Resident R10, and R95). Findings include: Review of the facility policy Hospice Care Policy dated 7/3/25, and previously dated 1/19/24, indicated that the facility will ensure that the resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. Review of Resident R10's admission record indicated she was initially admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS- periodic assessment of care needs) assessment dated [DATE], included diagnoses of anemia (too little iron in the body causing fatigue), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Review of Resident R10's medical record included a physician order to admit to hospice services dated 7/18/25. Review of Resident R10's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the clinical record indicated Resident R95 was admitted to the facility on [DATE].Review of Resident R95's quarterly MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of a physician order dated 7/17/24, indicated to admit to hospice services routine level of care with terminal diagnosis of neurocognitive disorder with Lewy bodies (a type of dementia).Review of Resident R95's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 8/21/25, at 10:34 a.m. Social Worker Employee E14 confirmed that the facility failed to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system and that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of Residents R10 and R5. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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	395682	A. Building B. Wing	08/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to prevent potential of cross contamination in one of three medication refrigerators (2B medication refrigerator), failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R82), and failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for four of 11 months (September 2024, October 2024, November 2024, and December 2024).Findings include: Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 7/3/25, and previously dated 1/19/24, indicated that the facility should ensure food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored. Review of facility policy Clean Dry Dressing Change dated 7/3/25, indicated where sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.Procedure: Perform hand hygiene Introduce self to patient/resident Confirm patient/resident ID Explain procedure to patient/resident, offer bathroom, analgesia Ensure privacy Set up clean field using a barrier, towel, chux, etc Position patient to visualize area to be dressed Perform hand hygiene Don clean gloves Check any dressing present, remove and wrap in gloves as you take gloves off, discard in trash bag Assess wound (if you need to touch the area perform hand hygiene and don new clean gloves) Perform hand hygiene Prepare supplies on field on field including any cleansing solution Don clean gloves Cleanse with ordered solution or normal saline soaked gauze pads (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Remove gloves and discard Perform hand hygiene and don clean gloves Apply new dressing(s) as ordered Assist patient/resident back to comfortable position Remove and discard gloves Perform hand hygiene Document procedure and update findings Notify provider if necessary Review of facility policy Infection Prevention and Control Program dated 7/3/25, previously dated 1/19/24, indicated the Infection Preventionist conducts surveillance of staff and residents for facility-associated or community associated infections and/or communicable diseases. During an observation and interview on 8/19/25, at 1:46 p.m. Licensed Practical Nurse (LPN) Employee E11 confirmed that there was an eight-ounce container of milk in the 2B Nurses Station medication refrigerator and that the facility failed to prevent potential cross contamination in one of three medication refrigerators. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. Review of Resident R82's [NAME] Data Set (MDS - a periodic assessment of care needs) dated 6/4/25, indicated diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Review of a physician order dated 8/1/25, indicated to cleanse right lateral malleolus (the outside portion of the ankle) with NSS (normal sterile saline), pat dry, apply moistened Triple Helix Collagen powder (used to aide in wound drainage absorption) to wound base, cover with silicone foam dressing and wrap ankle with conforming roll gauze every Monday, Wednesday, and Friday and as needed for loosening/soiling. During a dressing change observation on 8/21/25, from 1:58 p.m. to 2:10 p.m. LPN Employee E3 did not cleanse the resident's bedside table before setting up the clean field for the dressing change. After performing hand hygiene, LPN Employee E3 removed a pair of gloves from the front pocket of her scrub top and donned the gloves before removing the old dressing from Resident R82's ankle. Once the dressing was removed, Resident R82's ankle was placed on their bed linen with no clean field between the linens and Resident R82's uncovered wound. LPN Employee E3 performed hand hygiene and removed a pair of gloves form the front pocket of her scrub top and donned the gloves before opening the dressing supplies over the clean field. LPN Employee E3 did not perform hand hygiene or don clean gloves between opening the dressing supplies, cleansing the wound, and applying the new dressing. LPN Employee E3 did not cleanse Resident R82's bedside table after the procedure was completed and the clean field was discarded. (continued on next page)

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	395682	A. Building B. Wing	08/22/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/25, at 2:11 p.m. LPN Employee E3 confirmed the above observations and that the facility failed to implement infection control practices to prevent cross contamination during a dressing change. Review of the facility's Infection Control documentation for the previous 11 months (September 2024 - July 2025) failed to reveal surveillance for tracking infections for residents for four of ten 11 (September 2024, October 2024, November 2024, and December 2024). During an interview on 8/22/25, at 11:34 a.m. Infection Preventionist Employee E2 confirmed that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases for September 2024, October 2024, November 2024, and December 2024. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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	395682	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that an influenza immunization was offered to one of five residents (Resident R33), and failed to make certain that a pneumococcal immunization was offered to two of five residents (Residents R5 and R118).Findings include: Review of facility policy Resident Vaccination Policy dated 7/3/25, and previously dated 1/19/24, indicated influenza, pneumococcal, and COVID vaccination will be administered per provided orders. Consents/refusals/medical ineligibility will be documented in the electronic health record. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/2/25, indicated diagnoses of high blood pressure, depression, and anxiety. Question O0300 Pneumococcal Vaccine indicated Resident R5's Pneumococcal vaccination is not up to date. The reason for not receiving the Pneumococcal vaccine was coded with a dash (-) indicating the question was not answered. Review of Resident R5's clinical record failed to include documentation that the pneumococcal vaccination was offered and administered or declined. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and hyperlipidemia (high levels of fats in the blood). Question O0250: Influenza Vaccine indicated Resident R33 did not receive the influenza vaccine in the facility for this year's influenza vaccination season. The reason for not receiving the vaccination was coded as 5 not offered. Review of Resident R33's clinical record failed to include documentation that the influenza vaccination was offered and administered or declined. Review of the clinical record indicated Resident R118 was admitted to the facility on [DATE]. Review of Resident R118's MDS dated [DATE], indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and history of falling. Review of Resident R118's clinical record failed to include documentation that the pneumococcal vaccination was offered and administered or declined. During an interview on 8/21/25, at 12:15 p.m. Infection Preventionist Employee E2 confirmed that the facility failed to make certain that an influenza immunization was offered to one of five residents and an pneumococcal immunization was offered to two of five residents as required. 28 Pa. Code 211.5(f) Clinical records

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	08/22/2025

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination for two of five residents (Residents R5 and R33).Findings include: Review of facility policy Resident Vaccination Policy dated 7/3/25, and previously dated 1/19/24, indicated influenza, pneumococcal, and COVID vaccination will be administered per provided orders. Consents/refusals/medical ineligibility will be documented in the electronic health record. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/2/25, indicated diagnoses of high blood pressure, depression, and anxiety. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R5's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and hyperlipidemia (high levels of fat in the blood). Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R33's clinical record indicated the resident last received a COVID-19 vaccination on 5/20/22. Review of Resident R33's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 5/20/22. During an interview on 8/21/25, at 12:15 p.m. Infection Preventionist Employee E2 confirmed that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination for two of five residents as required. 28 Pa. Code 211.5(f) Clinical records