

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER Providence Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policy, observation and staff interview, it was determined that the facility failed to properly label and date food products, creating the potential for food-borne illness in the main kitchen's standing cooler rack and dry storage area. Findings include: Review of the facility's Food Preparation and Handling Policy dated 5/4/26, indicated Potentially Hazardous Foods (PHF)/Time Temperature Control for Safety Food (TCS) foods are kept refrigerated except when being handled. Refrigerated foods will be:-Covered for storage.-Cooked timely following defrosting.-Appropriately labeled and dated. Observation in the Main Kitchen on 8/3/26 at 9:20 a.m. the following was revealed:-Standing cooler rack had a tray with three separate chef's salads, and seven sandwiches that were not labeled and dated.-The dry storage area had a container of chicken gravy/bouillon opened and not labeled or dated. Interview on 8/3/26, at 9:30 a.m. Dietary Supervisor Employee E5 indicated the salads were from last evening's dinner meal and they, along with the sandwiches, should have been labeled and dated. Dietary Supervisor Employee E5 confirmed the chicken gravy/bouillon should have been labeled and dated. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of clinical records, observations and staff interviews, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for three of four residents (Resident R26, R178, and R179) and failed to provide the right to a dignified dining experience for one of two lunches observed (2B Nurse unit Lunch). Findings include: Review of facility policy Indwelling Urinary Catheter Care dated 5/4/26, indicated that clinical staff may provide urinary catheter care. Such care will help to prevent catheter association urinary tract infections. Check drainage tubing and bag to ensure that the catheter is draining properly, and no kinks are present. The urinary drainage bag must be placed below the bladder level, but not on the floor. Ensure drainage bag is covered with privacy/dignity bag. Review of admission record indicated Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 7/15/26, indicated diagnoses of diabetes, high blood pressure, and coronary artery disease (damage or disease in the heart's major blood vessels). Review of Resident R26's physician orders dated 10/15/25, indicated catheter care: provide privacy cover for drainage bag, every shift. During an observation on 8/3/26, at 10:02 a.m. Resident R26's catheter draining bag was observed hanging on the bedframe without a privacy cover applied. Review of admission record indicated Resident R178 was admitted to the facility on [DATE]. Review of Resident R178's MDS dated [DATE], indicated diagnoses of diabetes, high blood pressure, and depression. Review of Resident R178's physician orders dated 8/2/26, indicated catheter care: provide privacy cover for drainage bag, every shift. During an observation on 8/3/26, at 10:10 a.m. Resident R178's catheter draining bag was observed hanging on the bedframe without a privacy cover applied. Review of admission record indicated Resident R179 was admitted to the facility on [DATE]. Review of Resident R179's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R179's physician orders dated 7/30/26, indicated catheter care: provide privacy cover for drainage bag, every shift. During an observation on 8/3/26, at 10:15 a.m. Resident R179's catheter draining bag was observed hanging on the bedframe without a privacy cover applied. During an interview on 8/3/26, at 10:38 a.m. Registered Nurse Employee E14 stated, They should be covered, and confirmed Resident R26, R178, and R179's catheter draining bags did not have a privacy cover and that the facility failed to ensure that care was provided in a way that maintained Resident R26, R178, and R179's dignity. Review of admission record indicated Resident R39 was admitted to the facility on [DATE]. Review of Resident R39's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure, and diabetes. Review of Resident R39's care plan dated 6/25/26, indicated staff to feed resident all meals. Review of Resident R39's physician orders dated 7/25/26, indicated staff feed. During a lunch observation on 2B Nursing floor on 8/3/26, at 12:30 p.m. Resident R39 was sitting upright in bed. Nurse Aide (NA) Employee E19 was standing beside the bed feeding the resident. During an interview on 8/3/26, at 12:36 p.m. NA Employee E19 stated, I should be sitting down while I'm feeding but I don't know where his chair is. During an interview on 8/3/26, at 2:00 p.m. Director of Nursing confirmed that the facility failed to provide the right to a dignified dining experience for one of two lunches observed (2B). Pa. Code: 211.10(d) Resident care policies. Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **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 conduct care plan conferences and failed to ensure a resident or resident representative was notified in advance of care conference meetings for three of three residents (Resident R26, R39, and R91). Findings include: Review of facility policy Comprehensive Care Planning dated 5/4/26, indicated an interdisciplinary plan of care will be established and updated as indicated for every resident. The interdisciplinary team includes the participation of the resident or representative. An explanation must be included in a resident's medical record if participation is determined not to be practicable for the development of the resident's care plan. Review of admission record indicated Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/15/26, indicated the diagnoses of diabetes, high blood pressure, and coronary artery disease (damage or disease in the heart's major blood vessels). During a review of care plan conferences on 8/7/26, at 9:01 a.m. indicated that the last care conference held was on 1/29/26. Resident R26 failed to have a documented quarterly care conference in the following months: April 2026 July 2026 Review of admission record indicated Resident R39 was admitted to the facility on [DATE]. Review of Resident R39's MDS dated [DATE], indicated the diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes. During a review of care plan conferences on 8/7/26, at 9:09 a.m. indicated that an admission care conference was held on 10/1/25, with no attendees list except the staff member. Resident R39 failed to have a documented quarterly care conference in the following months: January 2026 May 2026 Review of admission record indicated Resident R91 was admitted to the facility on [DATE]. Review of Resident R91's MDS dated [DATE], indicated the diagnoses of insomnia (difficult sleeping), anxiety, and amyotrophic lateral sclerosis (ALS, a progressive neurological disorder which results in weakened muscles and deformity). During an interview on 8/4/26, at 11:07 a.m. Resident R91 stated he had only been to one care conference since admission and that he has not been invited to any other care conferences. During a review of care plan conferences on 8/7/26, at 9:16 a.m. indicated that an admission care conference was held on 6/4/25. Resident R91 failed to have a documented quarterly care conference in the following months: September 2025 December 2025 March 2026 June 2026 During an interview on 8/7/26, at 9:26 a.m. the Social Worker Aide Employee E18 confirmed the above missing quarterly care conferences for Resident R26, R39, and R91. During an interview on 8/7/26, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct care plan conferences and failed to ensure a resident or resident representative was notified in advance of care conference meetings for three of three residents (Resident R26, R39, and R91). 28 Pa. Code 201.29 (a) Resident rights.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 three of five residents sampled with facility-initiated transfers (Residents R4, R10, and R72), 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 five resident hospital transfers (Residents R4 and R10), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for three of five resident hospital transfers (Residents R4, R10, and R72). Findings include: Review of facility policy Discharge Planning reviewed 5/4/26, indicated that the transfer or discharge is documented in the resident's medical record and necessary information is communicated to the receiving health care institution or provider. Review of admission 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 6/19/26, indicated the diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), depression, and multiple sclerosis (a disease that affects central nervous system). Review of the clinical record indicated Resident R4 was transferred to the hospital on 5/14/26, and returned to the facility on 5/19/26. 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 and failed to have documentation of a bed hold policy given to the resident or representative. During an interview on 8/6/26, at 12:08 p.m. Regional Director of Clinical Services Employee E3 confirmed that there was no evidence that the State Ombudsman office was notified for Resident R4's transfer to the hospital. Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/23/26, indicated diagnoses of diabetes, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and depression. Review of the clinical record indicated Resident R10 was transferred to the hospital on 4/5/26, and returned to the facility on 4/6/26. Review of Resident R10'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 and failed to have documentation of a bed hold policy given to the resident or representative. During an interview on 8/6/26, at 12:10 p.m. Regional Director of Clinical Services Employee E3 confirmed that there was no evidence that the State Ombudsman office was notified for Resident R10's transfer to the hospital. Review of admission record indicated Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated the diagnoses of high blood pressure, chronic pain, and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of the clinical record indicated Resident R72 was transferred to the hospital on 6/10/26, and returned to the facility on 6/10/26. Review of (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R72'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. During an interview on 8/4/26, at 9:44 a.m. Registered Nurse Employee E14 confirmed that the facility failed to document resident information sent to the acute hospital for Resident R4, R10, and R72's transfers and failed to document that a bed hold policy was given to resident or representative for Resident R4 and R10. During an interview on 8/6/26, at 12:14 p.m. Regional Director of Clinical Services Employee E3 confirmed that there was no evidence that the State Ombudsman office was notified for Resident R72's transfer to the hospital. During an interview on 8/6/26, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of five residents sampled with facility-initiated transfers (Residents R4, R10, and R72), failed to notify the resident or resident's representative of the facility bed-hold policy for two of five resident hospital transfers (Residents R4 and R10), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for three of five resident hospital transfers (Residents R4, R10, and Resident R72). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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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 record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for four of six residents (Residents R2, R14, R135, and R155). Findings include: Review of facility policy Resident Weight Policy dated 7/20/26, and previously dated 5/4/26, indicated 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. Weights will be recorded in the electronic health record. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and anxiety. During an observation on 8/3/26, at 9:58 a.m. Resident R2's right hand was observed wrapped with gauze and secured with tape. Review of Resident R2's active physician orders failed to include an order for a treatment for the resident's right hand. Review of a nursing progress note dated 7/25/26, stated, Overheard resident yelling Come on from inside of his room. Upon entering the room resident was laying diagonally in his bed with his legs hanging out. Resident said that he was trying to get himself out of bed because he was in his parent's room and didn't want to be there anymore. Told resident that this nurse would get his aide and that we would assist him into his chair. Resident began yelling at this nurse saying that he wanted out now and that he wasn't going to wait. Resident lifted his legs and began attempting to kick this nurse and made multiple attempts to grab/hit. CAN (Certified Nurse Aide) entered room and this nurse asked for assistance with hooyer (a mechanical lift). While hooyer pad was being placed under resident, resident showed this nurse a skin tear on his right hand. Resident then said that this nurse had given him the skin tear (partial or complete separation of the skin's outer layers from the underlying tissue) by digging claws into him. Resident also said that he had a pimple on his knee that this nurse gave to him as well. While hooking resident up to the hooyer, this nurse was grabbed again by resident while he attempted to pull this nurse towards the bed. Resident also began punching this nurse with his other hand and repeatedly said he wanted to get out of his bed. Attempted to calm resident and told him again that we were getting him out of his bed but that he would need to let go of this nurse. Resident was eventually placed in his w/c (wheel chair). Placed steri strips (thin adhesive bandages that help seal minor wounds by pulling skin edges together) on skin tear to right hand. Called and informed provider and emergency contact. Supervisor informed. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/26, at 12:25 p.m. Wound Nurse Employee E11 confirmed there was no physician order for a treatment to Resident R2's right hand skin tear and stated, Steri strips are the preferred treatment for skin tears. There should probably be an order to monitor the steri strips. During this interview, Wound Care Nurse Employee E11 confirmed that the facility failed to make certain Resident R2 was provided appropriate treatment and care. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and depression. Review of a physician order dated 6/9/26, indicated to obtain weekly weight x 4 weeks, once a day on Monday. Review of Resident R14's June 2026 Medication Administration Record (MAR) revealed the weight was not obtained on the following: 6/22/26: the documented reason was Not Administered: unable to obtain 6/29/26: the documented reason was Not Administered: unable to obtain Review of Resident R14's clinical record failed to include additional documentation to indicate why the facility was unable to obtain the resident's weight on 6/22/26, and 6/29/26, as ordered by the physician. Review of the clinical record indicated Resident R135 was admitted to the facility on [DATE]. Review of Resident R135's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and mild cognitive impairment. Review of a physician order dated 6/11/26, indicated to obtain weekly weight x 4 weeks, once a day on Monday. Review of Resident R135's June 2026 MAR revealed the weight was not obtained on the following: 6/29/26: the documented reason was Not Administered: unable to obtain Review of Resident R135's clinical record failed to include additional documentation to indicate why the facility was unable to obtain the resident's weight on 6/29/26, as ordered by the physician. During an interview on 8/6/26, at 10:33 a.m. the Director of Nursing confirmed that the facility failed to make certain residents were provided appropriate treatment and care for Residents R14 and R135. Review of Resident R155's clinical record indicated the resident was admitted to the facility on [DATE]. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R155's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure in the arteries), depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During a review of Resident R155's clinical record on 8/4/26, at 9:02 a.m. indicated that resident was admitted with marks and blisters to her body and no treatment was ordered. During a review of progress notes dated 7/30/26, indicated that a contracted wound company seen Resident R155 and recommended skin prep (a barrier applied to skin) to blisters on her body. During a review of physician orders on 8/4/26, at 9:15 a.m. failed to reveal orders for skin prep to blisters that were recommended. During an interview on 8/4/26, at 9:28 a.m. Wound Nurse Employee E11 stated, I don't see an order for skin prep. Typically skin prep is an order so they can sign off that it was completed. They must have missed it, and confirmed that the facility did not follow the recommendations of the contracted wound company. During an interview on 8/4/26, at 11:30 a.m. Registered Nurse Employee E14 stated, I remember whoever rounded with the practitioner, they said it was not necessary to have done so they did not follow the recommendations, however the facility failed to have documented evidence of speaking to the practitioner concerning treatment for the blisters and the reason why the recommendations were not followed for care and treatment of Resident R155's blisters. During an interview on 8/4/26, at 11:45 a.m. Wound Nurse Employee E11 confirmed that the facility failed to make certain that residents were provided appropriate treatment and care for one of three residents (Resident R155). 28 Pa. Code: 201.14(a) Responsibility of licensee.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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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 review of facility policy, clinical record review, observations, 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 five residents (Residents R2, R14, and R160). Findings include: Review of facility policy Bed Rail dated 7/20/26, and previously dated 5/4/26, 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 R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and anxiety. Review of a physician order dated 3/6/26, indicated bariatric bed with bariatric mattress and bolster overlay, bilateral (both sides) assistive handrail to aide with positioning - check placement q (every) shift. Review of Resident R2's plan of care dated 9/25/25, indicated the resident is limited in ability to transfer self. Interventions included bariatric bed with bariatric mattress and bolster overlay, bilateral assistive handrail to aid with positioning - check placement q shift. During an observation on 8/3/26, at 9:58 a.m. bilateral enabler bars were observed on top of Resident R2's bed. Review of Resident R2's clinical record revealed the last Enabler-Restraint Observation 2 assessment was completed 10/6/25. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and depression. Review of a physician order dated 10/6/25, indicated may use grab/assist bars on bed to promote independence and sense of safety/security. Review of Resident R14's plan of care dated 10/7/25, indicated resident at risk for falling R/T (related to) antidepressant and antipsychotic medication use. Interventions included may use grab/assist bars on bed to promote independence and sense of safety/security. During an observation on 8/3/26, at 9:26 a.m. bilateral enabler bars were observed on top of Resident R14's bed. Review of Resident R14's clinical record revealed the last Enabler-Restraint Observation 2 assessment was completed 10/6/25. Review of the clinical record indicated Resident R160 was admitted to the facility on [DATE]. Review of Resident R160's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and hemiplegia (paralysis on one side of the body). During an observation on 8/3/26, at 10:02 a.m. bilateral enabler bars were observed on top of Resident R160's bed. Review of Resident R160's clinical record failed to include an order or ongoing assessment for the resident's bilateral enabler bar usage. Review of Resident R160's comprehensive care plan failed to include measurable objectives and timetables with specific interventions/services for use of enabler bars. During an interview on 8/5/26, at 1:16 p.m. Regional Director of Clinical Services (RDCS) Employee E3 stated enabler bar assessments should be done quarterly. During an interview on 8/5/26, at 1:16 p.m. RDCS Employee E3 confirmed 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 five residents (Residents R2, R14, and R160). 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.		

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER Providence Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Third Ave Beaver Falls, PA 15010	
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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluations at least once every 12 months for three of three nurse aide (NA) personnel records (NA Employee E23, NA Employee E24, and NA Employee E25). Findings include: Review of NA Employee E23's personnel file indicated a date of hire on 7/1/23. Review of NA Employee E23's personnel record failed to include an annual performance evaluation at least every 12 months as required. Review of NA Employee E24's personnel file indicated a date of hire on 7/1/23. Review of NA Employee E24's personnel record failed to include an annual performance evaluation at least every 12 months as required. Review of NA Employee E25's personnel record indicated a date of hire on 7/1/23. Review of NA Employee E25's personnel record failed to include an annual performance evaluation at least every 12 months as required. During an interview on 8/4/26, at 1:55 p.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluations at least once every 12 months for three of three nurse aide personnel records (NA Employee E23, NA Employee E24, and NA Employee E25). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.19(2) Personnel records.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide evidence medication regimen reviews (MRRs) were reviewed by the resident's attending physician monthly for three of five residents (Residents R2, R4 and R7). Findings include: Review of facility policy Medication Regimen Review dated 7/20/26, and previously dated 5/4/26, indicated the consultant pharmacist will provide the resident's MRRs to the facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and anxiety. Review of Resident R2's MRR dated 1/23/26, indicated the following recommendation from pharmacist to physician: The resident receives Seroquel (Quetiapine Fumarate), 100 mg (milligrams) am (in the morning) and hs (at night) for expressions or indications of distress related to dementia (e.g., dementia with psychosis). Please attempt a gradual dose reduction (GDR) of Quetiapine Fumarate 75 mg AM and 100 mg HS as a small GDR. Review of Resident R2's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/23/26. On 2/5/26, facility CRNP Employee E27 addressed the MRR, stating, Already being done and failed to indicate if the recommendation was accepted or declined. During an interview on 8/5/26, at 10:15 a.m. Medical Records Employee E2 confirmed CRNP Employee E27 addressed Resident R2's MRR dated 1/23/26, and that the facility failed to provide evidence that the MRR was reviewed by the resident's attending physician. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), multiple sclerosis (a disease that affects central nervous system), and depression. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R4's MRR dated 9/12/25, indicated the following recommendation from pharmacist to physician: PRN (as needed) indication missing. Oxycodone (used to treat pain) needs pain severity. Cephalexin (used to treat infections) without a stop date. Please document the stop date. Review of Resident R4's MRR dated 11/18/25, indicated the following recommendation from pharmacist to physician: PRN Tramadol (used to treat pain) needs pain severity Voltaren gel (a cream used to treat pain) needs amount in directions Review of Resident R4's MRR dated 1/2/26, indicated the following recommendation from pharmacist to physician: PRN orders have not been used for Hydroxyzine Pamoate (used to treat itching) and Meclizine (used to treat dizziness) with in the previous 30 days. Please consider discontinuing due to lack of use. Review of Resident R4's MRR dated 7/29/26, indicated the following recommendation from pharmacist to physician: Please reevaluate pain status. If pain is inadequately controlled, please consider adjustments to the current regimen. During an interview on 8/5/26, at 10:15 a.m. Medical Records Employee E2 confirmed that the facility failed to provide evidence that the MRR's were reviewed by the resident's attending physician for Resident R4. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and arthritis (swelling and pain in one or more of your joints). Review of Resident R7's MRR dated 1/27/26, indicated the following recommendation from pharmacist to physician: The resident receives multiple antidepressants for depression with similar mechanism of actions. SNRI (serotonin and norepinephrine reuptake inhibitor) and SSRI (selective serotonin reuptake inhibitors) concomitantly (at the same time) without documentation in the medical record of an adequate response to monotherapy. Please evaluate if resident could be titrated to a single agent reducing risk for serotonin related side effects. Possibly duloxetine 60mg daily could be titrated. Review of Resident R7's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/27/26. On 2/6/26, facility CRNP Employee E28 addressed the MRR, stating, accepted and decreased the duloxetine to 40mg. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/5/26, at 10:08 a.m. Medical Records Employee E2 confirmed CRNP Employee E28 addressed Resident R7's MRR dated 1/27/26, and that the facility failed to provide evidence that the MRR was reviewed by the resident's attending physician. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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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 four of five medications carts (2C2 Medication Cart, 2A Medication Cart, 2B Medication Cart, and 1B Medication Cart) and one of six resident rooms (Resident R74). Findings include: Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 7/20/26, previously dated 5/4/26, indicated 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 or opened. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Review of United States Food and Drug Administration (FDA) approved manufacturer prescribing information for Lantus (insulin glargine) for the 10 mL (milliliter) multiple-dose vial and 3 mL single-patient-use prefilled pen, dated 6/2023, indicated to store unused Lantus in a refrigerator between 36 degrees F (Fahrenheit) and 46 degrees F. Review of the United States FDA approved manufacturer prescribing information for Humalog (insulin lispro) for the 3 mL single-patient-use prefilled pen, dated 5/2025, indicated to store unopened Humalog (insulin lispro) in a refrigerator between 36 degrees F and 46 degrees F. Review of the United States FDA approved manufacturer prescribing information for Novolog (insulin aspart) for the 3 mL single-patient-use prefilled pen, dated 2/2023, indicated to store unopened Novolog (insulin aspart) in a refrigerator between 36 degrees F and 46 degrees F. During a medication pass observation on 8/4/26, at 9:01 a.m. Registered Nurse (RN) Employee E13 walked into a resident's room and failed to lock and secure the 2B Medication Cart. During an interview on 8/4/26, at 9:07 a.m. RN Employee E13 confirmed that the 2B Medication Cart was not locked and left unattended. During a medication cart review on 8/4/26, at 9:40 a.m. the narcotic drawer on 2C2 Medication Cart was not locked and secured. During an interview on 8/4/26, at 9:45 a.m. RN Employee E14 confirmed that 2C2 Medication Cart was (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sitting in the hallway unattended and that the narcotic drawer was not locked and secure. During an observation on 8/5/26, at 9:08 a.m. of the 2A Medication Cart revealed the following: Resident R14's Lantus insulin (long-acting insulin) vial was unopened in the box, the vial still contained the manufacturer seal and was not stored in the refrigerator prior to opening Resident R14's insulin lispro pen (a pre-filled pen containing rapid-acting insulin), no open date noted Resident R14's open Lantus insulin vial, no open date noted Resident R84's Troujeo pen (insulin glargine, a pre-filled pen containing long-acting insulin), no open date noted Resident R85's insulin lispro pen, no open date noted Resident R95's insulin glargine pen (a pre-filled pen containing long-acting insulin), no open date noted Resident R95's insulin glargine pen not open, still contained the manufacturer seal and was not stored in the refrigerator prior to opening Resident R97's insulin glargine pen, no open date noted Resident R127's Novolog insulin pen (a pre-filled pen containing rapid-acting insulin), no open date noted Resident R158's Trelegy inhaler (a medication used to prevent and treat respiratory distress), no open date noted Resident R158's Albuterol inhaler (a medication used to relax muscle in the airways), no open date noted Resident R186's Polymyxin B (an antibiotic used to treat bacterial infections in the eye) eye drops, no date noted During an interview on 8/5/26, at 9:25 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the above observations and that the facility failed to properly store medications in the 2A Medication Cart. During an observation on 8/5/26, at 9:57 a.m. of the 1B Medication Cart revealed the following: Latanoprost 0.05% eye drops dated 6/8/26. Interview on 8/5/26, at 9:58 a.m. LPN Employee E29 confirmed the eye drops were dated 6/8/26. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission record indicated Resident R74 admitted to the facility on [DATE]. Observation of Resident R74 on 8/3/26, at 11:42 a.m. indicated two bottles of eye drops at bedside. Neither bottles were labeled with an open date as required. Interview and observation on 8/3/26, at 11:45 a.m. Registered Nurse (RN) Employee E4 confirmed the eye drop bottles failed to be labeled with an open date as required. 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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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, resident records, a facility tour, observations, and staff interview it was determined that the facility failed to utilize proper food handling procedures during the lunch meal creating the potential for cross contamination for one out of five residents (Residents R97), failed to prevent cross contamination during a medication administration for one of five med pass observations (2B Med Pass), failed to follow proper use of personal protective equipment (PPE) for one of four residents (Resident R91), and failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for eight of twelve months (September 2025, through April 2026). Findings include: Review of the facility's Food Preparation and Handling Policy dated 5/4/26, indicated in order to avoid cross-contamination, single-use gloves will be used when handling ready-to-eat food directly with hands. Review of facility policy Transmission Based Precautions and Isolation dated 5/4/26, indicated precautions will be used when a potential for transmission of infectious agents are present. Contact precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the environment. Gloves, gowns are to be worn and masks, if needed. Review of facility policy Infection Prevention and Control Program dated 5/4/26, indicated it is the policy to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control, and reduce the risk of acquiring and transmitting infections. To conduct surveillance of communicable disease and infectious outbreaks. Particular focus of the program will be on conducting risk assessment, surveillance, reducing health care associated infections, limiting transmission of disease, immunization, promoting antibiotic stewardship, and reporting as necessary. Review of the admission record indicated Resident R97 admitted to the facility on [DATE]. Observation of the lunch meal service in the main dining area of the first floor on 8/4/26, at 11:40 a.m. Transportation Aide Employee E9 was observed assisting Resident R97 by opening a dinner roll from its package and opening a sandwich wrapped in plastic wrap. The employee failed to utilize gloves and touched the food directly with her hands. Interview on 8/4/26, at 11:45 a.m. the Director of Nursing was informed of the observation for Resident R97's lunch assistance. During a medication pass observation on 2B hallway on 8/4/26, at 9:01 a.m. Registered Nurse (RN) Employee E13 pushed the medications out of the blister packs onto an ungloved hand and put the medication into a medicine cup to administer to the resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/4/26, at 9:07 a.m. RN Employee E13 confirmed not having gloves on when handling resident medications and that the facility failed to prevent cross contamination during a medication administration for one of five med pass observations (2B Med Pass). Review of admission record indicated Resident R91 was admitted to the facility on [DATE]. Review of Resident R91's MDS dated [DATE], indicated the diagnoses of insomnia (difficult sleeping), anxiety, and amyotrophic lateral sclerosis (ALS, a progressive neurological disorder which results in weakened muscles and deformity). Review of Resident R91's physician orders dated 7/24/26, indicated Isolation/Transmission-Based Precautions: Contact Isolation. During an observation on 8/4/26, at 10:11 a.m. Resident R91 had contact isolation signage hanging on the door and PPE was available for staff use. On 8/4/26, at 10:42 a.m. Licensed Practical Nurse (LPN) Employee E12 entered Resident R91's room and failed to apply appropriate PPE, as ordered. During an interview on 8/4/26, at 10:50 a.m. LPN Employee E12 confirmed that she failed to apply PPE and follow proper use of PPE to prevent the spread of infections for Resident R91. Review of the facility's Infection Control Program on 8/5/26, at 10:15 a.m. for September 2025, through July 2026, failed to include documented evidence of infection surveillance and tracking for the facility for eight of twelve months (September 2025, through April 2026). During an interview on 8/5/26, at 3:16 p.m. Director of Nursing (DON) reviewed the facilities infection control documents with State Agency (SA) and was unable to provide evidence of the facilities infection control surveillance and tracking of infections in the facility. DON stated, I haven't been here that long. I started to oversee the Infection Control in May. If we don't have anything in these binders, then we don't have it. That is how we can monitor all the infections we have and provide education if needed. During an interview on 8/7/26, at 12:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to implement an infection control program that included a system of surveillance/tracking to identify possible communicable diseases or infections for eight of twelve months (September 2025, through April 2026). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.28 (b)(1)(e)(1) Management. 28 Pa Code: 211.10 (d) Resident care policies.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of the facility policy and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for eight of 12 months (September 2025, through April 2026). Findings include: Review of facility Antimicrobial Stewardship Program policy dated 5/4/26, indicated facility will focus on avoiding unnecessary or inappropriate use. It will be overseen by Infection Preventionist, Medical Director, Pharmacist, nursing, and leadership. Review of facility Infection Prevention and Control Program policy dated 5/4/26, indicated it is the policy to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control, and reduce the risk of acquiring and transmitting infections. To conduct surveillance of communicable disease and infectious outbreaks. Particular focus of the program will be on conducting risk assessment, surveillance, reducing health care associated infections, limiting transmission of disease, immunization, promoting antibiotic stewardship, and reporting as necessary. Review of the facility's Infection Control Program for September 2025, through July 2026, failed to include documented evidence that antibiotic monitoring and appropriate usage was completed from September 2025, through April 2026. During an interview on 8/5/26, at 3:16 p.m. Director of Nursing reviewed the facilities infection control documents with State Agency (SA) and was unable to provide the facilities antibiotic stewardship program and stated, I haven't been here that long. I started to oversee the Infection Control in May. If we don't have anything in these binders, then we don't have it. During an interview on 8/7/26, at 8:30 a.m. Regional Director of Clinical Services Employee E3 stated, I found an antibiotic stewardship binder in one of the offices last night and confirmed that it had reports from the lab in it and failed to include any facility tracking of antibiotics and had previous survey information in it. During an interview on 8/7/26, at 12:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to implement an antibiotic stewardship program eight of 12 months (September 2025, through April 2026). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 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 facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the Pneumonia vaccine for three of five residents (Resident R4, R26, and R72). Findings include: Review of facility policy Resident Vaccination dated 5/4/26, indicated resident or responsible party will be asked about prior vaccinations at admission. Prior doses of influenza, pneumococcal, COVID (respiratory illness), and other vaccines will be documented in the immunization portal in the electronic health record. Vaccinations will be administered by provider's orders. Review of admission 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 6/19/26, indicated the diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), depression, and multiple sclerosis (a disease that affects central nervous system). MDS Section O- Special treatment, Procedures, and Programs, O0300 Pneumococcal vaccine up to date is coded as a no. Reason is coded as a 3, not offered. During a review of Resident R4's immunization record on 8/6/26, at 10:10 a.m. indicated that on 10/30/25, the consent was not obtained and the reason listed was status to be determined. Education provided to the resident or the representative was not checked. The facility failed to provide documented evidence that the pneumococcal vaccine was offered and that education was provided. Review of admission record indicated Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's MDS dated [DATE], indicated the diagnoses of diabetes, high blood pressure, and coronary artery disease (damage or disease in the heart's major blood vessels). MDS Section O- Special treatment, Procedures, and Programs, O0300 Pneumococcal vaccine up to date is coded as a no. Reason is coded as a 3, not offered. During a review of Resident R26's immunization record on 8/6/26, at 10:17 a.m. indicated that on 10/29/25, the consent was not obtained and the reason listed was unable to obtain data. The facility failed to provide documented evidence that the status of the pneumococcal vaccine was discussed with the attending physician. Review of admission record indicated Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated the diagnoses of high blood pressure, chronic pain, and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). MDS Section O- Special treatment, Procedures, and Programs, O0300 Pneumococcal vaccine up to date is coded as a no. Reason is coded as a 3, not offered. During a review of Resident R26's immunization record on 8/6/26, at 10:24 a.m. indicated that on 10/30/25, the consent was not obtained and the reason listed was status to be determined. Education provided to the resident or the representative was not checked. The facility failed to provide documented evidence that the pneumococcal vaccine was offered and that education was provided. During an interview on 8/6/26, at 10:32 a.m. the Director of Nursing stated, We should have followed up with vaccinations, and confirmed that the facility failed to provide accurate and timely documentation related to the Pneumonia vaccine for three of five residents (Resident R4, R26, and R72). 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documents, resident and staff interviews, it was determined that the facility staff failed to provide services in the facility with reasonable accommodation of resident needs and preferences for enabler bars for one of five residents (Resident R105). Findings include: Review of the facility policy Facility Resident Handbook last reviewed 5/4/26, indicated reasonable accommodation as the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents. Review of the admission record indicated Resident R105 admitted to the facility on [DATE]. Review of Resident R105's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/27/26, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), high blood pressure, and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids). Review of Occupational Therapy Evaluation dated as start of care 7/22/26, indicated Functional Assessment Bed Mobility: Resident requires assistance, however, will not currently address in treatment plan (minimal assistance for bed mobility, would be able to complete with stand by assistance if assist bars are present). Review of Resident R105's clinical record on 8/5/26, failed to include an observation for enabler bars. Observation on 8/3/26, at 9:20 a.m. Resident R105 was lying in bed. Interview on 8/3/26, at 9:20 a.m. Resident R105 indicated she wanted enabler bars to help position herself in the bed. She indicated she has asked for enabler bars but has not heard back since her admission on [DATE]. Observation and interview on 8/3/26, at 9:30 a.m. Registered Nurse (RN) Employee E4 confirmed Resident R105 did not have enabler bars on the bed and would look into it. Observation on 8/5/26, at 12:37 p.m. Resident R105 was resting in bed, and enabler bars were not present. Interview on 8/5/26, at 12:45 p.m. Occupational Therapy (OT) Employee E6 indicated the process for obtaining enabler bars as follows: therapy will determine on their evaluations whether residents can use their upper extremities. Then they notify nursing to put an observation (assessment of risk) in to have enabler bars put on if appropriate. Then a maintenance request is filled out. It can take a few days to a week to obtain the enabler bars. Interview on 8/5/26, at 12:50 p.m. OT Employee E7 referenced her OT Evaluation dated 7/22/26, and indicated the resident would benefit from enabler bars and indicated the observation probably never got put in the computer. The facility uses a verbal notification for the observations to be completed. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 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 facility policy, resident family interviews and documentation, and staff interviews it was determined that the facility failed to assist a resident family with forming a family group for three of three resident families (Resident Family Representatives FR116, FR121, and Resident Family Representative FR300). Findings include: The facility Resident Handbook-resident groups document last reviewed 7/20/26, indicated that the resident has a right to organize and participate in resident groups. 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. The facility must consider the views of a resident or family group and act promptly. Review of the facility family council minutes dated 8/20/25, indicated that families were informed of several upcoming events, families shared suggestions during the meeting, families were thanked for their attendance, and the next family council meeting would be announced at a later date. Review of Family Group meeting minutes dated 8/20/25, failed to include documentation that resident families had discussed not wanting to continue with future meetings or that communication was provided by the facility that the facility would cease to conduct Family Group meetings. During an interview on 8/6/26, at 10:22 a.m. Resident Family R116 and Resident Family R121 indicated the facility no longer provides a family meeting and had previously provided a family meeting monthly. During a phone interview on 8/6/26, at 12:56 p.m. Resident Family Representative FR300 was interviewed and stated the following: The last Administrator in her tenor there, she stopped the family council meeting. They would have the meeting every quarter. She eliminated that. She said it was best to address the issue with the appropriate apartment at the time. We are lacking feedback because the meeting has stopped. About 2 to 2.5 years ago they offered meetings every month. A lot of things did not get addressed. Facility administration made them every 3 months and eliminated the meeting around Thanksgiving and Christmas. I spoke to Activities Director Employee E16 and spoke (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to another staff, and they said the family meeting was not occurring any longer. During an interview on 8/6/26, at 1:41 p.m. the Nursing Home Administrator (NHA) stated, August 2025 was the last Family Council meeting, the previous administration did not want to continue the meetings. We are going to be sending out communication asking family's desire to continue the meetings. The prior administration did not move forward with the practice; the practice has not officially been disbanded from the facility. During an interview on 8/6/26, at 1:55 p.m. Activities Director Employee E16 was asked when last family council meeting was and who stopped the meeting, she stated: it was August of 2025. The prior administrator stopped it. Family council met every three months. It was quarterly prior. The family did ask previous Administrator about the family meetings; I was told we were not having them and there was no formal communication to families. During an interview on 8/6/26, at 2:11 p.m. information was disseminated to the Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional Director of Clinical Services Employee E3 that the facility failed to assist a resident family with forming a family group for four of four resident families as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(4)Management.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident clinical records, facility documents, and staff interview it was determined that the facility failed to provide a Skilled Nursing Advanced Beneficiary Notice of Non-coverage (SNF-ABN) with the estimated amount of nursing services that will be charged for one of three sampled resident records (Resident R120). Findings include: Review of Resident R120's admission record indicated he was originally admitted on [DATE]. Review of Resident R120's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 6/18/26, indicated he had diagnoses that included artificial hip joint, cellulitis (bacterial infection of the skin causing redness, aches, and swelling), and dysphagia (difficulty swallowing). Review of Resident R120's census document (a form showing room number and payor source) indicated that he was admitted on Medicare Part A on 3/27/26, and his payor changed on 4/19/26 to private pay. Review of Resident R120's social services note dated 4/17/26, indicated he was provided a NOMNC form (Notice of Medicare Non-Coverage NOMNC: a form provided to residents to inform them of the facilities determination to end a Medicare based services). The note indicated that the form was verbally reviewed with his wife as well. Resident R120 was unable to sign. Both he and his family acknowledge and agree with the NOMNC and do not intend to appeal. Review of Resident R120's social services notes and clinical nurse notes did not indicate that Resident R120 or his wife were provided with a SNF-ABN form (Skilled Nursing Facility Advanced Beneficiary Notice of non-coverage: SNF-ABN-a form to inform those residents of items and services no longer deemed eligible for coverage under Medicare Part A) reviewing services no longer covered under Medicare Part A. During an interview on 8/5/26, at 10:19 a.m. Regional Director of Clinical Services Employee E3 confirmed that the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of non-coverage (SNF-ABN) form to inform Resident R120 or his family of items and services no longer deemed eligible under Medicare Part A as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2)(3) Management.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of five medication carts (2B Medication Cart). Findings include: Review of facility policy HIPAA Privacy dated 5/4/26, indicated the facility will treat Protected Health Information (PHI) in accordance with these policies. Facility may not use or disclose PHI. During a medication pass observation on 8/4/26, at 9:03 a.m. the Registered Nurse (RN) Employee E13 left the medication cart unattended in the hallway with the computer screen open displaying resident information. During an interview on 8/4/26, at 9:07 a.m. RN Employee E13 confirmed that the 2B Medication Cart computer screen was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information and that the facility failed to maintain the confidentiality of residents' medical information on one of five medication carts (2B Medication Cart). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. code: 211.5(b)(1)(2) Medical records. 28 Pa. Code: 211.12(d)(1)(3) Nursing services.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interview it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three floors (Second floor). Findings include: During a tour with the Maintenance Employee E9 on 8/5/26, at 11:00 a.m. on the Second Floor (2B), the following were observed: Resident R171 room was found with a missing part of a baseboard under the window. Left side of the hallway were missing baseboards periodically down the hall. Right side of the hallway were missing baseboards periodically down the hall. During an interview on 8/5/26, at 11:12 a.m. Maintenance Employee E15 stated that the machine must be hitting them and they took them off and confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three floors (Second floor). 28 Pa. Code 201.18(b)(3)(e)(2) Management. 28 Pa code 211.12(d)(1) Nursing services.		

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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 policy, clinical record review, 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 two of four residents (Residents R2 and R87). Findings include: Review of facility policy Restraint Policy dated 7/20/26, previously dated 5/4/26, indicated a physical and/or chemical restraint will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use. A physical restraint is 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 R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and anxiety. Review of a physician order dated 3/6/26, indicated bariatric bed with bariatric mattress and bolster overlay, bilateral (both sides) assistive handrail to aide with positioning - check placement q (every) shift. Review of Resident R2's plan of care dated 9/25/25, indicated the resident is limited in ability to transfer self. Interventions included bariatric bed with bariatric mattress and bolster overlay, bilateral assistive handrail to aid with positioning - check placement q shift. During an observation on 8/3/26, at 9:58 a.m. Resident R2 was observed lying in bed and the mattress had bilateral raised edges on the top and bottom portions. Further review of Resident R2's clinical record failed to identify any assessments or ongoing evaluations for the usage of bolsters on the resident's mattress. Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE]. Review of Resident R87's MDS dated [DATE], indicated diagnoses of hemiplegia (paralysis on one side of the body), anxiety, and depression. Review of a physician order dated 11/29/23, indicated resident to use bilateral bed rail bolsters while in bed as tolerated. Review of Resident R87's plan of care dated 12/26/23, indicated the resident has a history of falling R/T (related to) decreased safety awareness, alteration in cognition, impulsivity. Interventions included keep bed in lowest position with brakes locked. Floor mat to door side of bed, contour mattress with bolster overlay, bilateral foam wedges for positioning, every shift, as tolerated. During an observation on 8/3/26, at 10:26 a.m. Resident R87 was observed lying in bed and the mattress had bilateral raised edges on the top and bottom portions. Further review of Resident R87's clinical record failed to identify any assessments or ongoing evaluations for the usage of bolsters on the resident's mattress. During an interview on 8/5/26, at 1:16 p.m. Regional Director of Clinical Services Employee E3 confirmed that the facility failed to assess the functional status of the individual resident to determine if the use of a bolster is a restraint for two of four residents (Residents R2 and R87). 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.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, personnel records and staff interview, it was determined that the facility failed to conduct an FBI background check on agency personnel prior to working on the nursing unit for one out of six personnel records (Agency Nurse aide (NA) Employee E20). Findings include: The facility Personnel abuse policy dated 8/25/25, and last reviewed 7/20/26, indicated that the facility will not employ or otherwise engage individual s who have been found guilty of abuse, neglect or mistreatment of residents. It is the policy to undertake background checks of all employees. The facility will do the following prior to hiring a new employee and conduct background checks in accordance with State law. Review of Agency Nurse aide (NA) Employee E20's personnel record indicated he was hired to work at the facility on 7/15/26, his orientation was completed at the facility on 7/15/26, and Agency Nurse aide (NA) Employee E20's worked on two shifts (7/26/26 and 8/1/26). Review of Agency Nurse aide (NA) Employee E20's indicated the staff had lived outside of Pennsylvania within the past two years. Review of Agency Nurse aide (NA) Employee E20's personnel record indicated an FBI background check dated 6/1/23. Review of Agency Nurse aide (NA) Employee E20's personnel record did not include an updated FBI background check prior to this start date at the facility. During an interview on 8/6/26, at 10:00 a.m. the Director of Human Resources Employee E21 confirmed that Agency Nurse aide (NA) Employee E20 had in fact lived outside of Pennsylvania within the past two years. During an interview on 8/6/26, at 2:11 p.m. information was disseminated to the Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional Director of Clinical Services Employee E3 that the facility failed to conduct an FBI background check on Agency Nurse aide (NA) Employee E20 prior to working on the nursing unit as required. 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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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 facility policy, resident records, resident council minutes, facility investigation documents, incidents submitted to the local State field office, resident interview, and staff interviews it was determined that the facility failed to submit a report of an allegation of verbal abuse for one of four sampled resident records (Resident R9). Findings include: The facility Personnel abuse policy dated 8/25/25, and last reviewed 7/20/26, indicated that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms. All allegations of abuse must be reported immediately to the Administrator and to the applicable State agency. Review of Resident R9's admission record indicated she was admitted to the facility on [DATE]. Review of Resident R9's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs), dated 6/10/26, indicated she had diagnoses that included hypertension (a condition impacting blood circulation through the heart related to poor pressure), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and hyperlipidemia (elevated lipid levels within the blood). Review of Resident Council meeting minutes dated 6/30/26, indicated that Resident R9 told staff that a staff-person had yelled at her. Review of June 2026 grievance documentation did not indicate a grievance related to the allegation. Review of facility investigation documents indicated a disciplinary action dated 6/29/26 for Nurse aide Employee E26 related to this incident, and a retraining related to effective communication. Review of reported incidents of abuse to the State did not include Resident R9's verbal abuse allegation. During an interview on 8/5/26, at 9:53 a.m. the Activities Director Employee E16 was asked if Resident R9's allegation of verbal abuse occurred during council and if it was reported, and she stated: yes. that happened. Resident R9 was not upset, but Director of Human Resources Employee E21 did speak with the aide. During an interview on 8/5/26, at 9:56 a.m. the Director of Human Resources Employee E21 was asked if she recalled retraining an aide or discussing a Resident R9 verbal abuse allegation in June 2026, and she stated: no. I do not recall. During an interview on 8/5/26, at 10:00 a.m. Resident R9 was interviewed about the verbal abuse allegation mentioned during the June 2026 resident council meeting and stated: yes, that was taken care of. She was loud. I did get mad. I cursed her back. The aide did not resign. During an interview on 8/5/26, at 10:40 a.m. the Director of Nursing (DON) confirmed that the facility failed to submit a report of Resident R9's allegation of verbal abuse as required. 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c)(d) Resident Rights 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services		

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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 review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for one of three residents (Resident R164). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated September 2025, indicated the following: Section O0110 - Special Treatments, Procedures, and Programs - Check all of the following treatments, procedures, and programs that were performed. D1 Suctioning (clean or sterile medical procedure used to clear thick mucus and secretions from the trachea and lower airway when a resident cannot cough them up) performed while a resident of this facility and within the last 14 days. Review of the admission record indicated Resident R164 admitted to the facility on [DATE]. Review of Resident R164's MDS dated [DATE], indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), heart failure (heart doesn't pump blood as well as it should), and stroke (damage to the brain from an interruption of blood supply). Section O0110 D1. Suctioning failed to be indicated as required. Review of Resident R164's physician order dated 7/20/26, indicated to check trach mask is in place, oxygen is in place, and check the need for suctioning, trach care and oral (mouth) care four times a day. Review of Resident R164's current care plan indicated suction trach and oral care every shift and every two hours as needed. Review of Resident R164's Medication Administration Record dated 7/20/26, through 7/26/26, indicated suction tracheostomy (a surgical opening made through the front of the neck into the windpipe/trachea) every shift was performed on 7/22/26, 7/23/26, 7/24/26, 7/25/26, and 7/26/26. Interview on 8/5/26, at 12:01 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E8 confirmed Resident R164's MDS dated [DATE], Section O0110 D1. Suctioning failed to be indicated as required. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the resident for one of three residents reviewed (Resident R181). Findings include: Review of the facility's Interim Baseline Care Plan Policy dated 5/4/26, indicated that within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed. Review of the admission record indicated Resident R181 admitted to the facility on [DATE], with the diagnoses of pneumonitis (lung infection due to inhalation of food and vomit), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of Resident R181's physician order dated 7/31/26, indicated Isosource 1.5 (enteral feeding formula). Confirm rate is programmed at 60 ml/hr (milliliters/hour). Confirm total volume to infuse. Review of Resident R181' Nursing-Admission/readmission Observation 3 document dated 7/31/26, at 2:39 p.m. indicated - Does the resident have a gastric/enteral tube? Answer documented as no. GI (gastro-intestinal) appliances for enteral feeding use: gastrostomy tube failed to be marked as present. The bottom of the document Baseline Care plan section indicated dietary needs will be met as ordered, and failed to specify the need for gastrostomy tube and/or enteral feedings as required. Interview on 8/7/26, at 11:10 a.m. Regional Nurse Consultant Employee E3 confirmed the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the resident for one of three residents reviewed (Resident R181). 28 Pa Code 211.10(a) Resident care policies.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain that residents received proper treatment for pressure ulcers/injuries (PU/PI's - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of four residents (Resident R8 and R181). Findings include: Review of the facility's Pressure Injury Prevention and Management Policy, dated 5/4/26, indicated residents admitted with existing pressure injuries will receive necessary treatment and services consistent with professional standards of practice, to promote healing and prevent infection. Pressure injuries identified will be assessed initially and at least weekly thereafter until closed. All assessments will include the following elements: -Location and stage (if pressure injury);-Size (length and width, location and extent of any undermining or tunneling/sinus tract;-Exudate (drainage) if present, the type, color, odor, and appropriate amount;-Pain, if present the nature and frequency;-Wound bed color and type of tissue;-Appearance of surrounding tissue and any evidence of infection.-Treatment - pressure injuries identified will be documented and orders obtained from providers for treatment Review of admission 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 7/21/26, indicated the diagnoses of malnutrition (lack of sufficient nutrients in the body), cancer, and chronic pain. Section M-Skin Conditions M0100 A marked with an X, indicating resident has a pressure ulcer/injury. Review of Resident R8's care plan edited on 7/30/26, indicated impaired skin integrity pressure injury to coccyx (tail bone area) related to pressure, decreased mobility, incontinence, and poor nutrition. Goal: Coccyx ulcer will not increase in size. Ulcer will not exhibit signs of infection. Review of Resident R8's physician orders dated 8/5/26, indicated Cleanse coccyx with normal saline (NSS- a mixture of sodium chloride and water), then apply Santyl (a chemical agent for removing dead skin cells), nickel thick to wound base, then apply calcium alginate (a highly absorptive dressing that creates a protective gel and maintains a moist wound environment), and cover with a dry dressing. To be completed once a day. During a dressing change observation on 8/5/26, at 12:27 p.m. Licensed Practical Nurse (LPN) Employee E17 removed the old dressing from Resident R8's pressure ulcer with the date marked 8/3/26. LPN Employee E17 confirmed the date of 8/3/26, on the old dressing. During an interview on 8/5/26, at 1:07 p.m. LPN Employee E17 confirmed the date of the dressing change (8/5/26), the date that was on the old dressing removed (8/3/26), and that Resident R8's (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings failed to be completed on 8/4/26. Review of Resident R8's Medication Administration Record (MAR) dated August 2026, indicated on 8/4/26, dressing was not changed and was marked other. RN Employee E17 confirmed that the other documentation was from RN Employee E17 and stated that Hospice usually does the dressing changes, but it is our responsibility to ensure they are completed and confirmed that the medical record failed to include what the other reason was for not changing the dressing per physician orders. During an interview on 8/5/26, at 2:37 p.m. with Director of Nursing (DON) and Regional Director of Clinical Services Employee E3, the State Agency reported the dressing failed to be changed on 8/4/26, as neglect. DON stated, Hospice should not be doing dressing changes. Nursing should have followed the physician orders, and the dressing should have been changed on 8/4/26. During an interview on 8/5/26, at 2:45 p.m. the DON confirmed that the facility failed to follow physician orders and make certain that Resident R8 received proper pressure ulcer treatment. Review of the admission record indicated Resident R181 admitted to the facility on [DATE], with the diagnoses of pneumonitis (lung infection due to inhalation of food and vomit), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of Resident R181's Nursing-Admission/readmission Observation 3 document dated 7/31/26, at 2:39 p.m. indicated Integumentary System (skin) location of pressure injury/ulcer as left foot. Location - heel. Skin and pressure injury/ulcer treatments were blank. Further review of Resident R181's clinical record failed to include measurements of the pressure injury, stage of pressure injury, wound description, preventive measures, and/or treatment for the pressure injury on the left heel. Interview on 8/7/26, at 11:20 a.m. Registered Nurse (RN) Employee E4 confirmed the facility failed to make certain that residents received proper treatment for pressure ulcers/injuries for Resident R181. 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)(5) Nursing services.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (G- Tube, a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents (Resident R181). Findings include: Review of the facility's policy Continuous or Non-bolus Timed Tube Feeding Procedure dated 5/4/26, indicated nurses will administer enteral feeding (liquid nutrition) as ordered by the physician through a regulated tube feeding set with volumetric control or via pump. Rinse syringe with hot water after each use. Discard and replace syringe and other reusable supplies every day. Date reusable supplies. Review of the admission record indicated Resident R181 admitted to the facility on [DATE], with the diagnoses of pneumonitis (lung infection due to inhalation of food and vomit), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of Resident R181's physician order dated 7/31/26, indicated Isosource 1.5 (enteral feeding formula). Confirm rate is programmed at 60 ml/hr (milliliters/hour). Confirm total volume to infuse. Review of Resident R181's care plan dated 8/3/26, indicated resident is at increased nutritional risk related to gastric tube use. Enteral feeding/supplements to support normal lab levels. Observation on 8/3/26, at 12:15 p.m. Resident R181's tube feeding bag was hanging on a pole with another bag of water hanging on the pole. Each bag failed to be labeled with resident's name, the formula, the rate, the date or the time it was hung. Interview on 8/3/26, at 12:20 p.m. Registered Nurse (RN) Employee E4 confirmed Resident R181's tube feeding bag was hanging on a pole with another bag of water hanging on the pole and that each bag failed to be labeled with resident's name, the formula, the rate, the date or the time it was hung. Observation on 8/4/26, at 9:15 a.m. Resident R181's tube feeding bag was hanging on a pole with another bag of water hanging on the pole. Each bag failed to be labeled with resident's name, the formula, or the rate. Interview on 8/4/26, at 9:18 a.m. Licensed Practical Nurse (LPN) Employee E17 confirmed Resident R181's tube feeding bag was hanging on a pole with another bag of water hanging on the pole. Each bag failed to be labeled with resident's name, the formula, or the rate. 28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interviews, and resident observations it was determined that the facility failed to include care and management of a PICC line (peripherally inserted central catheter - a long thin flexible tube inserted into a vein in the upper arm and threaded to a large vein near the heart) consistent with professional standards of practice for one of two residents (Resident R181). Findings include: Review of the facility policy Central Vascular Access Device Flushing and Locking dated 5/4/26, indicated a prescriber order is required to flush/lock a catheter. The order must include flushing/locking agent, strength/concentration, volume (amount), and frequency. Documentation in the medical record includes, but is not limited to date and time, prescribed flushing/locking agent, site assessment, resident response to the procedure and/or medication, and patient significant other teaching. Review of the admission record indicated Resident R181 admitted to the facility on [DATE], with the diagnoses of pneumonitis (lung infection due to inhalation of food and vomit), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of Resident R181's admission orders failed to include orders for the care and management of a PICC line. Review of Resident R181's care plan failed to include orders for the care and management of a PICC line. Review of Resident R181's progress note dated 7/31/26, at 3:53 p.m. indicated resident has midline (a thin, soft tube placed into a large vein in the upper arm) in place to the left upper extremity. Observation on 8/3/26, at 10:30 a.m. Resident R181 was lying in bed with a PICC line noted to her left upper arm. Interview and observation on 8/3/26, at 10:35 a.m. Registered Nurse (RN) Employee E4 confirmed Resident R181 was lying in bed with a PICC line noted to her left upper arm. Further review of Resident R181's progress note dated 8/6/26, indicated PICC line removed from left upper arm per order. Interview on 8/7/26, at 9:56 a.m. RN Employee E4 confirmed the facility failed to include care and management of a PICC line consistent with professional standards of practice for Resident R181. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy, interview with staff and resident, it was determined the facility failed to provide respiratory care consistent with professional standards of practice for one of three residents receiving oxygen (Resident R80) and failed to provide tracheostomy care consistent with professional standards of practice for one of three residents (Resident R164). Findings include: Review of the facility's Oxygen Administration (all routes) Policy dated 5/4/26, indicated nurses will administer oxygen via the specified route as ordered by a provider. When oxygen not in use, store dry oxygen tubing, nasal cannula or trach mask in plastic bag. Change tubing, mask, cannula weekly and document in the Electronic Health Record (E.H.R.). Review of the facility's Tracheostomy Care Policy dated 5/4/26, indicated tracheostomy (a surgical opening made through the front of the neck into the windpipe/trachea) care, including changing the inner cannula will be performed daily and as needed, unless otherwise directed by the provider. Review of the clinical record indicated Resident R80 was admitted to the facility on [DATE]. Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/30/26, indicated diagnoses of depression, low blood pressure, and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. During an observation on 8/3/26, at 10:15 a.m. Resident R80 was lying in bed with oxygen on. The nasal cannula was not dated. Review of physician order dated 3/8/26, indicated clean oxygen concentrator and filter, change tubing weekly, every Friday. Review of physician order dated 5/23/26, indicated Oxygen at three liters per minute via nasal cannula (NC- a lightweight, flexible tube used to deliver oxygen to people with breathing difficulties), at night or as needed. During an interview on 8/3/26, at 10:30 a.m. Registered Nurse (RN) Employee E14 confirmed that the oxygen tubing failed to have a date on it and confirmed that the facility failed to provide appropriate respiratory care for Resident R80. Review of the admission record indicated Resident R164 admitted to the facility on [DATE]. Review of Resident R164's MDS dated [DATE], indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), heart failure (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(heart doesn't pump blood as well as it should), and stroke (damage to the brain from an interruption of blood supply). Review of Resident R164's physician order dated 7/20/26, indicated to check trach mask is in place, oxygen is in place, and check the need for suctioning, trach care and oral (mouth) care four times a day. Further review of Resident R164's physician order dated 7/20/26, indicated oxygen via ATM (aerosolized trach mask - a lightweight plastic cup placed over a neck stoma) at 3liters to maintain oxygen saturation at 90 percent or greater, every shift. Review of Resident R164's current care plan indicated suction trach and oral every shift and every two hours as needed. Further review of Resident R164's care plan indicated provide oxygen via ATM. Change tubing weekly; clean equipment and filters weekly. Observation on 8/3/26, at 11:35 a.m. Resident R164 was lying in bed connected to oxygen via ATM. Underneath the ATM, the tracheostomy had heavy thick mucus visible. The inside of the trach mask was soiled in mucus. The ATM tubing was not dated, the nebulizer tubing was not dated and not stored in a bag as required. Observation on 8/3/26, at 11:36 a.m. Resident R164 had suction equipment on a stand near the bed. The end of the suction catheter tubing was not stored in a bag as required. Observation and interview on 8/3/26, at 11:37 a.m. RN Employee E4 confirmed Resident R164's appearance that underneath the ATM, the tracheostomy had heavy thick mucus visible. The inside of the trach mask was soiled in mucus. The ATM tubing was not dated, the nebulizer tubing was not dated and not stored in a bag as required; and the end of the suction catheter tubing was not stored in a bag as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documents and staff interview, it was determined that the facility failed to accurately complete the Facility Assessment. Findings include: A review of the Facility Assessment, dated 7/15/26, revealed the facility did not complete the template to indicate accurate information on the skill sets that are necessary to provide the level and types of care needed for the resident population; including specific medical equipment currently in use. The equipment that failed to be included in the facility's medical equipment section included: Automated External Defibrillator (AED a portable lifesaving device), Tracheostomy care and management, Life Vest (a wearable cardioverter defibrillator for residents at risk of sudden cardiac death), Wound Vac machines (a negative pressure system used for wound healing), and glucometer devices (portable machines used to check capillary blood sugar). During an interview on 8/7/26, at approximately 12:07 p.m. the Nursing Home Administrator confirmed that the facility failed to accurately complete the Facility Assessment. 28 Pa. Code 201.18(b)(3)(e)(2) Management.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of facility documentation, results of previous survey, and results of the current survey, it was determined that the facility Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed deficiencies. Findings include: The facility deficiencies and plans of correction for a State Survey and Certification (Department of Health) survey ending August 22, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. Findings of the current survey ending August 7, 2026, included deficiencies that were repeated from the previous survey of August 22, 2025, which are as follows: F604, F609, F628, F700, F880, F883, and PA1020. During an interview on 8/6/26, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility had multiple repeat deficiencies from the previous survey, and that the facility failed to correct quality deficiencies and ensure that plans to improve the delivery of care services effectively addressed those deficiencies. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 211.12(c)(d)(3) Nursing services.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for two of two crash carts (a cart that contains supplies in the event of an emergency) for two of six nursing units (Nursing units 1B and 2B). Findings include: Review of the facility's Emergency Equipment Check Policy dated [DATE], indicated emergency equipment/cart(s) will be checked daily and items which are outdated or opened will be replaced. The cart will be restocked promptly after any use. If a breakaway lock system is used, the cart will be checked daily to ensure the lock is intact. Contents will be checked monthly for expired items, assuming the cart is not accessed in the interim. During an observation of the facilities crash cart, located on the 2B Second Floor, on [DATE], at 9:40 a.m. revealed the following supplies to be expired: (1) Ambu bag (a handheld manual resuscitator used to provide positive pressure ventilation) was stored in an opened bag and expired [DATE]. During an interview on [DATE], at 9:50 a.m. Registered Nurse (RN) Employee E14 confirmed the expired Ambu bag for 2B Crash Cart. During observation of the facilities crash cart, located on Nursing unit 1B, on [DATE], at 11:00 a.m. revealed the following supplies to be expired: -First Ambu Bag (a hand-held tool used to push air into a person's lungs when they cannot breath well or stop breathing) was dated with an expiration date of [DATE].-Second Ambu Bag was dated with an expiration date of [DATE].-A bottle of Assure Prism glucometer strips (used to check capillary blood sugar) with an expiration date of [DATE]. During an interview and observation on [DATE], at 11:00 a.m. RN Employee E4 confirmed the Ambu bags and glucometer stirps were expired and should not be in the crash cart. 28 Pa Code: 201.14(a) Responsibility of licensee.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for one of five staff members (Registered Nurse (RN) Employee E22). Findings include: Review of RN Employee E22's personnel file indicated a date of hire on 7/1/23. Review of RN Employee E22's personnel file did not include annual in-service training on QAPI from 1/1/25 through 12/31/25. During an interview on 8/5/26, at 2:17 p.m. Assistant Director of Nursing Employee E10 confirmed that the facility failed to provide training on QAPI for one of five staff members (RN Employee E22). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		