STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395692	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Washington PA	90 Humbert Lane Washington, PA 15301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, published documents, clinical record review and staff interviews, it was determined that the facility failed to protect residents from neglect that resulted in actual harm of an impacted fracture of the right femur (thigh bone) for one of four residents (Resident R1). Findings include: Review of the facility policy dated 1/6/26, Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary. Review of the clinical record indicated Resident R1 was re-admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/31/26 included diagnoses of anxiety, chronic ischemic heart disease (plaque buildup restricts blood flow and oxygen to the heart), muscle weakness, and abnormal gait and mobility. Review of Section GG: Functional Abilities indicated that Resident R1 required substantial/maximal assistance for chair/bed-to-chair transfers. Review of a physician order dated 7/28/24 indicated Resident R1 transfer with a mechanical lift with the assist of two staff members. Review of a rehabilitation communication, dated 3/3/26, indicated that the resident has bed mobility with an assist of two members. Review of Resident's care plan revealed that transfer status and mobility were only added after the incident. Review of a progress note dated 5/30/26 at 11:01 a.m. indicated, while [NA] (nursing assistant) was doing care, resident yelling out when right leg is touched. A televisit was completed and an Xray was ordered and scheduled. Review of facility submitted information on 5/30/26 at 6:30 p.m., indicated Received a call from RN (registered nurse) Supervisor at approximately 0630 PM with a report that the x-ray on Resident R1 was positive for a femur fracture above the knee. No reports of any falls or trauma noted with the resident for the previous shift. Resident's son was notified and did not want his mother transferred to the hospital for any treatment for the fracture, to leave her at the facility. Resident was left in bed for the day, pain medication ordered and administered. Review of a facility investigation completed on 5/31/26, indicated that incident occurred on 5/29/26 during the 7 a.m. to 3 p.m. shift. Timeline of events obtained through interviews with all staff that cared for resident in the last 24 hours confirmed that there was no hoyer lift sling under the resident during this shift. It was determined that NA Employe E1 was responsible for resident during this shift. Review of an employee written statement by NA Employee E1, dated 5/31/26 at 9:30 a.m. indicated, I lifted the resident into her chair by standing her up using a bear hug and pivoting her into the chair. NA Employee E1 also stated that she did have the resident information sheet with transfer status but did not look before transferring resident and admitted to not using a hoyer lift. NA Employee E1 was an agency staff member and no longer allowed to work at the facility. State Surveyor attempted to reach NA Employee E1 by phone but unsuccessful. During interviews with staff to include Registered Nurses (RN), LPNs and NAs on 6/22/26, at approximately 12:00 p.m., indicated that transfer status is printed on the information sheets. During an interview on 6/22/26, at approximately 1:32 p.m. the Director of Nursing confirmed the facility failed to protect residents from neglect which resulted in actual harm for one of four residents (Resident R1).

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent injury that resulted in the actual harm of an impacted right femur fracture (thigh bone) for one of four residents (Resident R1). Findings include: Review of the facility policy Transfer/Lift Policy, dated 1/6/26, indicated it is the facility's policy to provide safe care for each resident and staff when having to physically transfer/lift a resident and all resident care will be provided in accordance with the individual resident's care plan.Review of the clinical record indicated Resident R1 was re-admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/31/26 included diagnoses of anxiety, chronic ischemic heart disease (plaque buildup restricts blood flow and oxygen to the heart), muscle weakness, and abnormal gait and mobility. Review of Section GG: Functional Abilities indicated that Resident R1 required substantial/maximal assistance for chair/bed-to-chair transfers. Review of a physician order dated 7/28/24 indicated Resident R1 transfer with a mechanical lift with the assist of two staff members. Review of a rehabilitation communication, dated 3/3/26, indicated that the resident has bed mobility with an assist of two members. Review of Resident R1's care plan revealed transfer and mobility status was not updated until after the incident. Review of a progress note dated 5/30/26 at 11:01 a.m. indicated, while [NA] (nursing assistant) was doing care, resident yelling out when right leg is touched. A telehealth visit was completed and an Xray was ordered and scheduled. Review of facility submitted information on 5/30/26 at 6:30 p.m., indicated Received a call from RN (registered nurse) Supervisor at approximately 0630 PM with a report that the x-ray on Resident R1 was positive for a femur fracture above the knee. No reports of any falls or trauma noted with the resident for the previous shift. Resident's son was notified and did not want his mother transported to the hospital for any treatment for the fracture, to leave her at the facility. Resident was left in bed for the day, pain medication ordered and administered. Review of a facility investigation completed on 5/31/26, indicated that incident occurred on 5/29/26 during the 7 a.m. to 3 p.m. shift. Timeline of events obtained through interviews with all staff that cared for resident in the last 24 hours confirmed that there was no hoyer lift sling under the resident during this shift. It was determined that NA Employe E1 was responsible for resident during this shift. Review of an employee written statement by NA Employee E1, dated 5/31/26 at 9:30 a.m. indicated, I lifted the resident into her chair by standing her up using a bear hug and pivoting her into the chair. NA Employee E1 also stated that she did have the resident information sheet with transfer status but did not look before transferring resident and admitted to not using a hoyer lift. NA Employee E1 was an agency staff member and no longer allowed to work at the facility. State Surveyor attempted to reach NA Employee E1 by phone but unsuccessful. During interviews with staff to include Registered Nurses (RN), LPNs and NAs on 6/22/26, at approximately 12:00 p.m., indicated that transfer status is printed on the information sheets. During an interview on 6/22/26 at approximately 1:32 p.m., the Director of Nursing confirmed the facility failed to provide adequate supervision to prevent injury that resulted in the actual harm of an impacted right femur fracture for one of three residents (Resident R1).