STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395717	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Nursing and Rehabilitation Center	100 Linwood Avenue Scranton, PA 18505

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 a review of facility policies, clinical records, facility investigative documentation, and resident and staff interviews, it was determined the facility failed to ensure one of 10 residents reviewed (Resident 1) remained free from emotional and psychosocial abuse, exploitation, and invasion of privacy when a staff member intentionally recorded the resident on a personal cellular telephone during toileting care and while the resident was using the toilet without the resident's knowledge or consent. This deficient practice resulted in actual psychosocial harm through humiliation, loss of dignity, and violation of the resident's privacy. This deficiency is cited as past noncompliance.Findings include:A review of a facility policy titled Resident Abuse & Neglect Prevention Program last reviewed by the facility on January 21, 2026, revealed each resident has the right to be free from abuse, neglect, misappropriation, and exploitation. The policy indicated that each resident has the right to be free from mistreatment and neglect. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy defined mental, emotional, or psychosocial abuse as the verbal or nonverbal infliction of anguish, pain or distress that results in mental or emotional suffering, including humiliation, harassment, threats of punishment, or deprivation. A review of a facility policy titled Videotaping, Photographing, and Other Imaging of Residents last reviewed by the facility on January 21, 2026, revealed residents will be protected from invasion of privacy and or abuse that might occur from photographs, videotapes, digital images, and recordings during resident care or other facility activities. The policy defined resident image as the likeness of a resident captured through still photography, videotaping, digital imaging, scans, audio recording, etc. A review of Resident 1's clinical record revealed the resident was admitted on [DATE], with diagnoses that included dementia with psychotic disturbance (a condition in which progressive memory loss and impaired thinking are accompanied by hallucinations or false beliefs), restlessness, and agitation. A review of Resident 1's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2026, revealed that Resident 1 was moderately cognitively impaired with a BIMS score of 9 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). The assessment revealed Resident 1 required moderate staff assistance for toilet transfers and transfers between the bed and wheelchair. A review of Resident 1's care plan dated June 20, 2025, revealed the resident exhibited behaviors including yelling out, making negative statements, paranoia, and crying. The care plan directed staff to explain care before providing assistance, maintain a consistent routine, speak in a calm and reassuring manner, and postpone care if the resident became combative until the resident regained composure. A review of facility provided investigative documentation revealed that on June 23, 2026, between 6:30 AM and 7:00 AM, Employee 2 Nurse Aide (NA) arrived for duty when Employee 1 Nurse Aide stated, Come here, you need to see this, and displayed a video on Employee 1's personal cellular telephone depicting Resident 1. During (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	an interview on July 1, 2026, at 9:39 AM Employee 2 stated Employee 1 NA showed both Employee 2, NA, and Employee 4, NA, the recording. Employee 2 stated the recording depicted Resident 1 in bed while Employee 1 repeatedly instructed the resident to get up without providing assistance. Employee 2 stated the recording then depicted Resident 1 being taken to the bathroom where Employee 1 continued recording while Resident 1 sat on the toilet using the bathroom. Employee 2 stated the recording further depicted Resident 1 asking for assistance off the toilet while Employee 1 responded, You can get in the chair. Employee 2 stated the recording later showed Resident 1 struggling to return to bed while repeatedly requesting help and ultimately kicking the wheelchair toward Employee 1 after assistance was not provided. Employee 2 stated that throughout the recording Employee 1 did not provide the moderate assistance required for Resident 1's toileting transfers despite the resident's repeated requests for help. Employee 2 immediately reported the incident to Employee 3, Licensed Practical Nurse (LPN).During an interview on July 1, 2026, at 10:01 AM Employee 4 confirmed Employee 1 displayed the recording to Employee 2 and Employee 4. Employee 4 stated the recording depicted Resident 1 asking for assistance, using the toilet while being recorded, requesting help to get off the toilet, struggling to return to bed, and kicking the wheelchair after assistance was not provided. Employee 4 further stated Employee 1 commented while recording, See this is why I have bruising. This is what I have to deal with. Employee 4 stated she was extremely upset after viewing the recording and immediately reported the incident with Employee 2 to Employee 3. During an interview on July 1, 2026, at 10:25 AM Employee 3, LPN, stated Employees 2 and 4 immediately informed her they had viewed a video showing Resident 1 being recorded while using the toilet. Employee 3 stated she immediately notified the Director of Nursing (DON) and checked on Resident 1.An interview with Employee 3 conducted on July 1, 2026, at 10:25 AM revealed she was working in her office on the morning of June 23, 2026, when Employees 2 and 4 approached her and reported they had viewed a video on Employee 1's personal cellular telephone depicting Resident 1 while the resident was using the bathroom. Employee 3 stated she did not personally view the video. Employee 3 stated she immediately sent a text message to the Director of Nursing (DON), then went to Resident 1's room, where the resident was seated. Employee 3 stated Employee 1 had already left the facility.A review of text message communications revealed Employee 3 sent a text message to the DON on June 23, 2026, at 7:23 AM stating, Need to talk to you ASAP. A review of telephone records revealed the DON returned the call at 7:24 AM, at which time Employee 3 informed the DON about the reported video. An interview with the DON conducted on July 1, 2026, at 10:50 AM revealed that after learning of the reported video, she immediately returned to the facility and initiated an investigation. A review of an employee witness statement submitted by Employee 1 via email to the facility on June 24, 2026, at 3:30 AM revealed Employee 1 wrote that on June 22, 2026, between 6:45 AM and 7:00 AM, Resident 1 was, in Employee 1's words, acting up while Employee 1 was assisting the resident to the bathroom. Employee 1 further wrote that Resident 1 repeatedly directed racial slurs toward Employee 1 and that Employee 1 recorded Resident 1 in the resident's room as video proof to protect herself. During a telephone interview conducted by the surveyor on July 1, 2026, at 11:00 AM Employee 1 confirmed recording Resident 1 on a personal cellular telephone. Employee 1 stated she recorded the resident because she was tired of the resident's behavior and stated Resident 1 repeatedly said, Come here @#$%^&* girl, you work for me. Employee 1 stated she wanted to record the video because she was tired of being mistreated by the resident and intended to show the recording to the DON. Employee 1 further stated she deleted the video before leaving the facility because she believed the DON would not care and there would be no repercussions for Resident 1's behavior. Employee 1 stated she did not understand why she was in trouble because she believed Resident 1 was the problem. When asked, Employee 1 acknowledged she knew facility policy prohibited recording residents but stated she felt she had no other choice. When requested to retrieve the recording from the deleted files on her cellular telephone, Employee 1 stated the video had been permanently deleted and could not be recovered. During an interview on July 1, 2026, at 12:45PM, the DON and Nursing (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Home Administrator confirmed the facility investigation determined Employee 1 did not follow the facility's abuse and neglect policy, prohibiting unauthorized photographing or recording of residents. The DON and Nursing Home Administrator confirmed Employee 1 was immediately removed from the work schedule and employment was terminated. The facility alleged past noncompliance. Facility documentation and interviews confirmed the following corrective actions were implemented immediately following the incident. Resident 1 was assessed for any injury. Employee 1 was immediately suspended. The facility completed an audit on all residents to determine if any other residents in the facility were affected. The facility immediately conducted facility wide education on the abuse/neglect policy, videotaping policy, and dementia care policy. To sustain compliance, the facility administration initiated a plan to conduct five random audits, regarding staff care, these audits are scheduled weekly for one week, bi-weekly for two weeks, and weekly for 1 month. The results of the audits are to be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) Committee for oversight and recommendations. The facility demonstrated that substantial compliance was achieved on June 25, 2026. Therefore, this deficiency is cited as past noncompliance. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of facility policies, facility investigative documentation, clinical records, and staff interviews, it was determined the facility failed to conduct a complete and thorough investigation of an allegation of abuse, neglect, and exploitation for one of 10 residents reviewed for (Resident 1).Findings include:A review of a facility policy titled Resident Abuse & Neglect Prevention Program last reviewed by the facility on January 21, 2026, revealed each resident has the right to be free from abuse, neglect, misappropriation, and exploitation. The policy indicated that each resident has the right to be free from mistreatment and neglect. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The policy further defined mental, emotional, or psychosocial abuse as the verbal or nonverbal infliction of anguish, pain, or distress that results in mental or emotional suffering, including humiliation, harassment, threats of punishment, or deprivation. A review of a facility policy titled Videotaping, Photographing, and Other Imaging of Residents last reviewed by the facility on January 21, 2026, revealed residents will be protected from invasion of privacy and or abuse that might occur from photographs, videotapes, digital images, and recordings during resident care or other facility activities. The policy defined a resident image as the likeness of a resident captured through still photography, videotaping, digital imaging, scanning, or audio recording. The policy revealed any image or recording that may reasonably be construed as humiliating or demeaning to a resident is considered resident abuse and will be reported and investigated. A review of a facility policy titled Investigation of Allegation of Abuse, Neglect, Misappropriation, or Exploitation and Resident Protection last reviewed by the facility on January 21, 2026, revealed the investigation will include a review of the completed incident investigation, an interview of the perpetrator, witnesses, the victim, and the resident's roommate if able. The policy detailed a review of all circumstances surrounding the incident and a review of surveillance videos, and any other official documentation received regarding the incident as available. A review of Resident 1's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2026, revealed that Resident 1 was moderately cognitively impaired with a BIMS score of 9 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). The MDS revealed Resident 1 required moderate staff assistance with toilet transfers (assistance getting on and off the toilet) and transfers between the bed and wheelchair. A review of Resident 1's care plan dated June 20, 2025, revealed the resident exhibited behaviors including yelling out, making negative statements, paranoia, and crying. The care plan directed staff to explain care before providing assistance, maintain a consistent routine, speak in a calm and reassuring manner, and postpone care if the resident became combative until the resident regained composure. A review of the facility's investigative documentation revealed that on June 23, 2026, Employee 2 Nurse Aide (NA) reported Employee 1 (Nurse Aide) NA had shown Employees 2 and 4 a video recorded on Employee 1's personal cellular telephone showing Resident 1 during resident care. The facility investigation determined Employee 1 had recorded Resident 1 in the privacy of the resident's room while providing care. The investigative documentation further revealed Employee 1 reported deleting the recording before leaving the facility. The investigation contained no documentation the facility attempted to verify Employee 1's statement that the recording had been permanently deleted. Specifically, the investigative documentation contained no evidence the facility requested Employee 1 retrieve the recording from the deleted files on the cellular telephone, examined the device to determine whether the recording remained recoverable, or otherwise attempted to verify the recording no longer existed. Because the facility did not attempt to verify whether the recording remained available, the investigation did not determine the complete content of the recording or whether the recording contained additional evidence regarding the allegation of abuse, neglect, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exploitation, invasion of privacy, or failure to provide required resident care beyond the information reported by witnesses. During an interview conducted on July 1, 2026, at 12:00 PM, the Nursing Home Administrator and Director of Nursing reviewed the facility's investigative documentation. The Nursing Home Administrator and Director of Nursing acknowledged the facility did not attempt to verify whether the recording remained on Employee 1's personal cellular telephone after Employee 1 reported deleting the recording.28 Pa Code 201.18(b)(1) Management.28 Pa Code 211.12(d)(1)(3)(5) Nursing services.