STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395845	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranberry Place	5 Saint Francis Way Cranberry Township, PA 16066

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** 46336 Based on review of facility policies, documents and clinical records and staff interviews, it was determined that the facility failed to protect residents from abuse and neglect which resulted in actual harm of abandonment and mental anguish for one of three residents (Resident R1) and resulted in actual harm of a tibial plateau fracture (a break in the upper tibia, the lower leg bone below the knee, that affects the knee joint) for one of three residents (Resident R3). Findings include: The facility's policy Abuse and Neglect - Clinical Protocol dated August 2024, indicated abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Also includes Neglect defined as the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Review of the facility's Job Description for Driver dated May 2004, indicated the duties and responsibilities of the Driver include driving residents to and from scheduled appointments using a company van, car, and/or bus. Maintains confidentiality and privacy of community/resident records and communicates with dignity and respect. Review of facility policy Activities of Daily Living dated August 2024, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs (activities of daily living) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems). (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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/24/25, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (the force of the blood against the artery walls is too high), and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Section C0500 indicated a Brief Interview for Mental Status (BIMS - is a screening test that aides in detecting cognitive impairment) score of 15. The distribution indicated 13-15 as cognitively intact. Review of Resident R1's care plan dated 3/21/25, indicated resident will have safe leave of absence. Review of facility provided documentation dated 3/25/25, at 3:21 p.m. indicated the facility received a voice mail from Resident R1's niece with concerns regarding Resident R1's ride to the hospital for a CT scan (a medical imaging technique that uses X-rays to create detailed images of the inside of the body) this morning. Resident R1 was alone with the driver, and it was fine on the way there, but on the way back the Driver Employee E1 took her from the hospital in Shadyside, and Resident R1 reported seeing signs for Murrysville and Monroeville. Driver Employee E1 then took Resident R1 to a neighborhood, pulled up to a house and left Resident R1 alone in the van for five to ten minutes and went into the house. Driver Employee E1 then came out of the house with a sandwich, and then returned her to Cranberry. It didn't sound good to the niece, but Resident R1 was terrified. Review of Driver Employee E1's witness statement dated 3/26/25, at 11:00 a.m. indicated he took Resident R1 to the hospital for an appointment. Once done, the driver headed back to the facility. The driver stopped at his personal house because he had forgotten his driver's license. He also realized that he left his personal house that morning without his breakfast sandwich or diabetic (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) medication and then ate the sandwich. Review of the Nursing Home Administrator's interview with Driver Employee E1 dated 3/26/25, at 10:48 a.m. indicated the Driver Employee E1 reported everything went well. When asked if when he picked Resident R1 up after the appointment, did he go anywhere else? Driver Employee E1 admitted he stopped at home for his wallet. When asked if he also grabbed a sandwich, he replied that he did and apologized. Review of Social Worker (SW) Employee E2's interview with Resident R1, dated 3/25/25, indicated the resident stated on the way back from the doctor's appointment, she noticed signs for Monroeville, Murrysville, and Ohio turnpike, that the trip was taking longer than on the way to the appointment. She didn't know what was happening. She didn't know if she was being kidnapped, was the driver stealing the van? Resident R1 stated she was scared and didn't know what to do. Then Driver pulled into a house, in a questionable neighborhood and left her alone in the van for five minutes. Stated she was frightened. Reported the driver returned with a sandwich. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/1/25, at 10:00 a.m. Resident R1 indicated I was so terrified. I wasn't going to say anything, but the therapist asked me what took so long at the appointment because they expected me back sooner. I started seeing all these signs of places we did not pass on the way there. I was so scared; I didn't dare say a word. I wondered if I was being kidnapped or the driver was perhaps stealing the van with me in it. I saw signs for McKeesport. He locked the wheelchair in but didn't put my belt on. He didn't say a word to me. Parked in this alley, left me there without saying anything, and went into a house. I didn't know where I was, when or if he was going to come back. I'm still terrified about it. Finally, about five to ten minutes later the driver came back, didn't say a word to me, and was eating a sandwich. When asked if she asked the driver any questions, Resident R1 indicated No, I didn't dare say a word, I was too afraid. Interview on 4/1/25, at 10:30 a.m. the Nursing Home Administrator and Director of Nursing indicated they fired Driver Employee E1. Indicated they were mortified of the driver's behavior. They verified that Resident R1 was terrified from the experience and would always have an escort to any outside appointment moving forward. They indicated they were grateful nothing happened to Resident R1 while she was unattended in the van, in the alley, in a questionable, unknown neighborhood. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), coronary artery disease (narrow arteries decreasing blood flow to heart), and hypertension (the force of the blood against the artery walls is too high). Review of Resident R3's care plan dated 3/3/25, indicated resident requires two staff members assistance using mechanical lift (machine that moves residents from point A to point B) for transfers. Review of facility provided documentation dated 3/22/25, at 8:00 p.m. indicated during a therapy session Resident R3 reported pain in her left knee. The session was stopped, the nurse and physician were notified. Resident R3 reported she twisted it over the weekend. X-rays were ordered and found a fracture of the left tibial plateau. Review of Resident R3's progress notes dated 3/24/35, at 4:54 p.m. indicated weekly fall review meeting held on 3/24/25. Resident R3 had a fall in the resident room on 3/21/25, due to an unassisted transfer. No injuries observed at the time of the incident. Physician and family notified. Kardex (a summary of care needs) reviewed. The resident requires assistance of two staff members using the mechanical lift for transfers. She is being screened this week under Part B therapy services. Review of Physical Therapist (PT) Employee E6's witness statement dated 3/26/25, indicated upon evaluation for a Physical Therapy scan Resident R3 reported severe (eight out of ten) pain in left knee. Resident had pain with palpation (touch) on left side of knee, pain with range of motion, and weight bearing. A Lidocaine (pain medication) patch located on the front of the left knee. Reported to nursing. Resident reported she twisted her knee when transferring back to bed over the weekend and stated nursing was aware. Review of Employee E7's witness statement dated 3/26/25, indicated Resident R3 could not remember how she was transferred but was certain that it was with only one person named NA Employee E14. Indicated her foot did not get caught but was in pain when she hit the bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of SW Employee E2's interview with Resident R3's unidentified roommate indicated roommate reported on Saturday, 3/22/25, heard her roommate Resident R3 scream as facility aide was transferring her either from bed to the chair or chair to the bed. Roommate reported she heard Resident R3 scream, My knee, my knee, my knee. Roommate reported she told NA Employee E14 to go slowly. NA Employee E14 replied to roommate I can do it. Mind your business. It's none of your business. Review of interview on 3/26/25, at 12:00 p.m. indicated the Director of Nursing interviewed NA Employee E14 who responded she transferred Resident R3 by herself from her wheelchair to her bed. She reported that during the transfer, Resident R3's leg got caught on the wheelchair. NA Employee E14 indicated after the transfer, she realized that Resident R3 was probably a transfer assist of two staff members, but she was not sure what resident's transfer status was at the time the transfer was completed. Review of Physician Employee E8's evaluation dated 3/27/25, at 12:24 p.m. indicated Resident R3 had knee pain and X-ray was ordered and found to have left lateral tibial plateau fracture. Resident R3 was seen in the emergency room , brace was placed and is non-weight bearing to left lower extremity. Resident R3 is now on Norco (pain medication) for pain. Resident R3 is tearful this morning due to the pain. She received the medication just prior to the physician's visit. Review of facility provided education dated 1/13/25, indicated a signed education by NA Employee E14 that stated my signature acknowledges that I know how to access the Kardex, how to identify a resident's transfer status and bed mobility status and that I understand that not following the Kardex is considered resident neglect. Review of the Five Why Analysis provided by the facility dated 3/26/25, indicated define the problem: Resident R3 has a left tibial plateau fracture. Why did this happen? NA Employee E14 transferred Resident R3 incorrectly and did not follow the Kardex. NA Employee E14 admitted she did not bother to look at the Kardex. Interview on 4/1/25, at 9:33 a.m. NA Employee E5 indicated I've asked the aides to show me, so they know how to find the Kardex. Interview on 4/1/25, at 9:50 a.m. NA Employee E10 indicated We look on the Kardex for how many are needed for transfer, or if they're a new admission I'll ask the nurse who got report from the hospital. Interview on 4/1/25, at 9:51 a.m. NA Employee E11 indicated The Kardex. Even agency aides have access to the Kardex for transfer status. Interview on 4/1/25, at 9:56 a.m. NA Employee E12 indicated We look on the Kardex for the transfer status or ask someone who knows them. Interview on 4/1/25, at 9:58 a.m. NA Employee E13 indicated We look on the computer for the transfer status. Interview on 4/1/25, at 1:00 p.m. the Director of Nursing confirmed NA Employee E14 was removed from the schedule and separated from employment due to not following the resident's plan of care resulting in a serious injury to Resident R3. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Telephonic interview on 4/3/25, at 10:30 a. m. the Nursing Home Administrator confirmed the facility failed to protect residents from abuse and neglect which resulted in actual harm of abandonment and mental anguish for one of three residents (Resident R1) and resulted in actual harm of a tibial plateau fracture for one of three residents (Resident R3). 28 Pa. Code 201.14(a)(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.29(a) Resident Rights. 28 Pa. Code 211.10(a)(d) Resident care policies. 28. Pa. Code. 211.12(d)(1)(2)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to revise/update care plans for three of three residents to accurately reflect the current status of the residents' needs (Residents R1, R2, and R3). Findings include: Review of the facility policy Care Plans, Comprehensive Person-Centered dated August 2024, indicated the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plans are revised as information about the residents and residents' condition change. Review of admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/24/25, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (the force of the blood against the artery walls is too high), and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Section C0500 indicated a Brief Interview for Mental Status (BIMS - is a screening test that aides in detecting cognitive impairment) score of 15. The distribution indicated 13-15 as cognitively intact. Review of Resident R1's care plan dated 3/21/25, indicated resident will have safe leave of absence. Review of facility provided documentation dated 3/25/25, at 3:21 p.m. indicated the facility received a voice mail from Resident R1's niece with concerns regarding Resident R1's ride to the hospital for a CT scan (a medical imaging technique that uses X-rays to create detailed images of the inside of the body) this morning. Resident R1 was alone with the driver, and it was fine on the way there, but on the way back the Driver Employee E1 took her from the hospital in Shadyside, and Resident R1 reported seeing signs for Murrysville and Monroeville. Driver Employee E1 then took Resident R1 to a neighborhood, pulled up to a house and left Resident R1 alone in the van for five to ten minutes and went into the house. Driver Employee E1 then came out of the house with a sandwich, and then returned her to Cranberry. It didn't sound good to the niece, but Resident R1 was terrified. Further review of Resident R1's care plan failed to include revisions for psychosocial well-being post traumatic event monitoring for changes in behavior, mood, diet, and over all well-being. Review of admission record indicated Resident R2 was admitted to the facility 7/24/24. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs dated 2/19/25, indicated the diagnoses of Alzheimer ' s Disease (a progressive disease that destroys memory and other important mental functions), Neurofibromatosis (a condition that causes tumors to form in the brain, spinal cord, and nerves), and chronic pain (persistent pain that lasts weeks to years). Section G0110 indicated assist of two for bed mobility. Review of facility provided documentation dated 3/8/25, indicated Resident R2 was sent to local hospital emergency room that diagnosed a closed head injury and frontal scalp laceration four cm (centimeters), and resident received eight staples to forehead area. Review of Resident R2's care plan failed to include revisions for psychosocial well-being post traumatic event monitoring for changes in behavior, mood, diet, and over all well-being. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated the diagnoses of End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), coronary artery disease (narrow arteries decreasing blood flow to heart), and Hypertension (the force of the blood against the artery walls is too high). Review of interview on 3/26/25, at 12:00 p.m. indicated the Director of Nursing interviewed NA Employee E14 who responded she transferred Resident R3 by herself from her wheelchair to her bed. She reported that during the transfer, Resident R3's leg got caught on the wheelchair. Review of Physician Employee E8's evaluation dated 3/27/25, at 12:24 p.m. indicated Resident R3 had knee pain and X-ray was ordered and found to have left lateral tibial plateau fracture. Resident R3 was seen in the emergency room , brace was placed and is non-weight bearing to left lower extremity. Resident R3 is now on Norco (pain medication) for pain. Resident R3 is tearful this morning due to the pain. She received the medication just prior to the physician's visit. Review of Resident R3's care plan failed to include revisions for psychosocial well-being post traumatic event monitoring for changes in behavior, mood, diet, over all well-being, pain management, or for skin checks relating to the brace use. Telephonic interview on 4/3/25, at 10:35 a.m. the Director of Nursing confirmed that the facility failed to revise/update care plans for three of three residents to accurately reflect the current status of the residents' needs (Residents R1, R2, and R3). 28 Pa. Code: S211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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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** 46336 Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance for bed mobility and transfers to prevent accidents which resulted in actual harm of a head injury for one of four residents (Resident R2) and resulted in actual harm a tibial plateau fracture (a break in the upper tibia, the lower leg bone below the knee, that affects the knee joint) for one of four residents (Resident R3). Findings include: Review of the facility policy Accidents and Incidents-Investigating and Reporting, dated August 2024, indicated all accidents occurring on our premises must be investigated and reported to the administrator. Review of facility policy Activities of Daily Living dated August 2024, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs (activities of daily living) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems). Interview with the Director of Nursing indicated the facility did not have a policy regarding bed mobility. Review of Libre Texts Medicine procedure 12.8.5: Procedure- Turning and Positioning the Patient in Bed, indicated to position yourself on the side of the bed that the patient will be turned to. Review of admission record indicated Resident R2 was admitted to the facility 7/24/24. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs dated 2/19/25, indicated the diagnoses of Alzheimer ' s Disease (a progressive disease that destroys memory and other important mental functions), Neurofibromatosis (a condition that causes tumors to form in the brain, spinal cord, and nerves), and chronic pain (persistent pain that lasts weeks to years). Section G0110 indicated assist of two for bed mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Kardex dated 3/7/25, indicated bed mobility assist of one. Review of facility provided document Witnessed Fall with Injury dated 3/8/25, indicated Nurse Aide (NA) Employee E3 called for help. Licensed Practical Nurse (LPN) Employee E4 went into residents' room and found Resident R2 on the floor with the NA holding a washcloth on residents head and blood on the floor. Blood pressure at the time elevated at 177/72. There is a two-inch laceration (a deep cut or tear in the skin that exposes the underlying soft tissue) on resident's head. Resident R2 said she was rolling onto her side to get changed and said, I' m going and then fell on to the floor. Review of facility provided documentation dated 3/8/25, indicated Resident R2 refused transfer to the emergency room and refused family contact be made until morning. Later in the morning around 8:45 a.m., resident agreed to transfer. She was sent to local hospital emergency room that diagnosed a closed head injury and frontal scalp laceration four cm (centimeters), and resident received eight staples to forehead area. Resident sent back to facility with orders for staple removal in ten days. Bed was elevated during the event while care was being performed. Kardex updated to include that resident is to roll towards caregiver during care. Review of Registered Nurse (RN) Employee E5's witness statement dated 3/8/25, indicated according to NA Employee E3, she was changing the resident's brief when the resident rolled over and leaned too far over and fell to the floor before she could catch her. Review of NA Employee E3's witness statement dated 3/8/25, indicated I was changing Resident R1's brief, she rolled over a tiny bit more so I could wash her better. With her head at 30 degrees, she leaned too far over, and her head went first onto the floor. I had my hand on her one hip, as I was cleaning her, I tried to catch her, but she was on the floor before I could stop her from falling. I noticed blood on the floor as I checked on her. I hurried out to the hall and yelled for help, grabbed a washcloth to put pressure on her open head to control the bleeding. Nurses arrived and took over. Review of Resident R2's Report Form for investigation of Alleged Abuse, Neglect, and Misappropriation of property dated 3/10/25, indicated Section VII Actions Taken as: Resident was provided education on rolling towards caregiver for care. NA Employee E3 was educated on rolling resident towards caregiver during incontinence care and reports understanding. Interview on 4/1/25, at 9:11 a.m. Resident R2 indicated about three weeks ago at 3:00 a.m. she had diarrhea and couldn't get up her left leg, it's paralyzed. Resident R2 turned on the right side and said to NA Employee E3 please, just watch my left leg. Resident R1 turned and they were just about done. Resident R2 was turned and said oh my gosh my leg left burning, NA Employee E3 needed to hold the leg. Resident R2 told the aide don ' t let go. NA Employee E3 turned had her hand on Resident R2's leg. NA Employee E3 was on the left side of the bed and rolled Resident R2 away from her toward the door. The side of resident's head was full of blood. Resident had a gash on the top of her head. She had to get eight staples put in her forehead. Interview on 4/1/25, at 1:00 p.m. the Director of Nursing confirmed NA Employee E3 should have rolled Resident R2 towards her body and that NA Employee E3 was educated to roll the resident towards the body, not away. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. (continued on next page)

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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	Review of Resident R3's MDS dated [DATE], indicated the diagnoses of End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), coronary artery disease (narrow arteries decreasing blood flow to heart), and Hypertension (the force of the blood against the artery walls is too high). Review of Resident R3's care plan dated 3/3/25, indicated Resident requires two staff members assistance using mechanical lift (machine that moves residents from point A to point B) for transfers. Review of facility provided documentation dated 3/22/25, at 8:00 p.m. indicated during a therapy session Resident R2 reported pain in her left knee. The session was stopped, the nurse and physician were notified. Resident R1 reported she twisted it over the weekend. X-rays were ordered and found a fracture to the left tibial plateau. Review of Resident R3's progress notes dated 3/24/35, at 4:54 p.m. indicated weekly fall review meeting held on 3/24/25. Resident R3 had a fall in the resident room on 3/21/25, due to an unassisted transfer. No injuries observed at the time of the incident. Physician and family notified. Kardex reviewed. The resident requires assistance of two staff members using the mechanical lift for transfers. She is being screened this week under part B therapy services. Review of Physical Therapist (PT) employee E6's witness statement dated 3/26/25, indicated upon evaluation for a PT scan Resident R3 reported severe eight out of ten pain in left knee. Resident had pain with palpation (touch) left side of knee, pain with range of motion, and weight bearing. A Lidocaine (pain medication) patch located on the front of the left knee. Reported to nursing. Resident reported she twisted her knee when transferring back to bed over the weekend and stated nursing was aware. Review of Employee E7's witness statement dated 3/26/25, indicated Resident R3 could not remember how she was transferred but was certain that it was with only one person named NA Employee E14. Indicated her foot did not get caught but was in pain when she hit the bed. Review of SW Employee E2's interview with Resident R3's unidentified roommate indicated roommate reported on Saturday, 3/22/25, heard her roommate Resident R3 scream as facility aide was turning her either from bed to the chair or chair to the bed. Roommate reported she heard Resident R3 scream, My knee, my knee, my knee. Roommate reported she told NA Employee E3 to go slowly. NA Employee E3 replied to roommate I can do it. Mind your business. It's none of your business. Review of interview on 3/26/25, at 12:00 p.m. indicated the Director of Nursing interviewed NA Employee E14 who responded she transferred Resident R3 by herself from her wheelchair to her bed. She reported that during the transfer, Resident R3's leg got caught on the wheelchair. NA Employee E14 indicated after the transfer, she realized that Resident R3 was probably a transfer assist of two staff members, but she was not sure what resident's transfer status was at the time the transfer was completed. Review of Physician Employee E8's evaluation dated 3/27/25, at 12:24 p.m. indicated Resident R3 had knee pain and X-ray was ordered and found to have left lateral tibial plateau fracture. Resident R3 was seen in the emergency room , brace was placed and is non-weight bearing to left lower extremity. Resident R3 is now on Norco (pain medication) for pain. Resident R3 is tearful this morning due to the pain. She received the medication just prior to the physician's visit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395845	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranberry Place	5 Saint Francis Way Cranberry Township, PA 16066

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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	Interview on 4/1/25, at 9:33 a.m. NA Employee E5 indicated I've asked the aides to show me, so they know how to find the Kardex. We always roll toward the body with one person. Interview on 4/1/25, at 9:50 a.m. NA Employee E10 indicated I always roll the resident towards me when asked how to roll a resident in bed by yourself, we look on the Kardex for how many are needed for transfer, or if they're a new admission I'll ask the nurse who got report from the hospital. Interview on 4/1/25, at 9:51 a.m. NA Employee E11 indicated towards you when asked how to roll a resident in bed by yourself and indicated agency aides even have access to the Kardex for transfer status. Interview on 4/1/25, at 9:56 a.m. NA Employee E12 indicated we look on the Kardex for the transfer status or ask someone who knows them. I always roll the patients toward me. Interview on 4/1/25, at 9:58 a.m. NA Employee E13 indicated I'd roll them towards me when asked how to roll a resident in bed by yourself. We look on the computer for the transfer status. Interview on 4/1/25, at 1:00 p.m. the Director of Nursing confirmed NA Employee E14 was removed from the schedule and separated from employment due to not following the resident's plan of care resulting in a serious injury to Resident R3. Interview on 4/1/25, at 1:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to make certain each resident received adequate supervision and assistance for bed mobility and transfers to prevent accidents which resulted in actual harm of a head injury for one of four residents (Resident R2) and resulted in actual harm of a tibial plateau fracture for one of four residents (Resident R3). 28 Pa. Code 201.14(a)(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.29(a) Resident Rights. 28 Pa. Code 211.10(a)(d) Resident care policies. 28. Pa. Code. 211.12(d)(1)(2)(5) Nursing Services.