

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Cranberry Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for 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 documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of three residents reviewed (Resident R3). Findings include: Review of the facility Abuse and Neglect - Clinical Protocol policy last reviewed 6/2025, indicated the nurse will assess the individual and document related findings; Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes 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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of the facility Resident Rights: policy last reviewed 6/2025, indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility, these rights include but not inclusive to being treated with respect, kindness and dignity, to be free from corporal punishment. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/16/25, indicated diagnoses of hypertension (high blood pressure), aphasia (affects ability to speak, understand, read, or write) and hemiplegia (one sided paralysis) right dominant side. Section C- cognitive patterns coded resident is rarely/never understood). During a review of documentation provided by the facility on 8/12/25, at 1:50 p.m. indicated on 8/5/25, a nurse alerted facility leadership that an aide hit Resident R3 during care multiple times. The nurse immediately stepped between the aide and resident and escorted the aide out of the resident's rooms. During an interview completed on 8/12/25, at 1:50 p.m. the Director of nursing confirmed the allegation of physical abuse was substantiated and Nurse Aid perpetrator Employee E9 was terminated and that the facility failed to ensure that residents were free from abuse for one of three residents reviewed (Resident R3). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(d)(1)(3)(e)(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