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	11/21/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council meeting minutes, and staff interview it was determined the facility failed to consider the views of a resident group and act promptly on recommendations concerning issues of resident care and life in the facility for three of three months (September, October, and November 2025). Findings include: Review of a Resident Representative Concern dated 11/7/25, stated She was left unattended in a wheelchair with no remote near her to press for help. Review of Resident Council Meeting Minutes dated 9/11/25, stated Residents unanimously expressed that staff do not leave their call bells in reach. Review of Resident Council Meeting Minutes dated 10/9/25, stated Residents unanimously expressed that staff do not leave their call bells in reach. Review of Resident Council Meeting Minutes dated 11/13/25, stated Residents unanimously expressed that staff do not leave their call bells in reach (all units/all shifts). During an interview on 11/21/25, at 1:41 p.m. the Director of Nursing confirmed that the facility failed to address resident group response by not effectively addressing concerns with call bells not being left within residents' reach. 28 Pa. Code: 201.18(e)(4) Management28 Pa. Code: 201.29(i) Resident Rights

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policies, clinical records, and staff interviews, it was determined that the facility failed to conduct a thorough investigation of an allegations of abuse for one of two residents (Resident R26).Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated June 2025, indicated that all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. The individual conducting the investigation documents the investigation completely and thoroughly. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. Review of the facility policy Abuse and Neglect- Clinical Protocol dated June 2025, indicated that sexual abuse is defined as non-consensual sexual contact of any type with a resident. Review of the clinical 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 10/19/25, indicated diagnoses of high blood pressure, malnutrition (insufficient nutrients in the body) and low back pain. Review of documentation provided by the facility dated 11/12/25 stated the following: On 11/11/25 around 1830 (6:30 p.m.), the resident [Resident R26] reported to staff that his roommate [Resident R27] was in his bed and that he fondled his leg and groin. Resident R26 was visibly shaken, cry, and stating he was afraid of what his roommate might do. The resident reports that he previously reported this and nothing was done. During an interview on 11/20/25, at approximately 1:00 p.m. the Director of Nursing (DON) confirmed that the facility had conducted an investigation of the incident and provided an Investigation File of documents regarding the investigation that included written statements. During an interview on 11/20/25, at 2:30 p.m. Nurse Supervisor (NS) Employee E10 confirmed that she was working on the evening of the above incident that occurred on 11/11/25, and that she was made aware of the situation from a phone call that she received from Registered Nurse (RN) Employee E10, who stated that Nurse Aide (NA) Employee E11 had walked into Resident R26's room while the incident was occurring, as she was responding to Resident R26's yelling for help. NS Employee E10 had stated that she was also informed by Resident R26's family that they had previously reported this concern to Licensed Practical Nurse (LPN) Employee E12. During an interview on 11/20/25, at 2:59 p.m. LPN Employee E12 confirmed that Resident R26's family had approached her in the past regarding Resident's roommate trying to get into his bed, but that it was not relayed to her that the situation was sexual in nature, therefore she did not report any sexual abuse. LPN Employee E12 stated If I was told about that [sexual abuse] I would have reported in right away. Review of the Investigation File did not reveal any written statements from NA Employee E11 who had been the first to respond to the situation. Review of the Investigation File did not reveal any clarification that LPN Employee E12 was not told of any previous sexual abuse from Resident R26's roommate. During an interview on 11/21/25, at 12:46 p.m. the DON confirmed that no written statement was obtained from NA Employee E11. During an interview on 11/21/25, at 12:47 p.m. the DON was asked by State Agency (SA) to account for any investigation regarding LPN Employee E12's knowledge of any prior sexual abuse incidents. DON stated that she had conducted a detailed interview with LPN Employee E12 who had disclosed that she was only told of the roommate wandering into his bed, and was not informed of any inappropriate sexual behavior. During an interview on 11/21/25, at 12:49 p.m. the DON was asked by SA for documentation regarding the above interview with LPN Employee E12, and the DON replied that this interview was not documented. During an interview on 11/21/25, at 12:50 p.m. the DON confirmed that the facility failed to conduct a thorough investigation for allegation of abuse. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1) Management.28 Pa Code: 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R24).Findings include:Review of facility policy Administering Medications dated June 2025, indicated medications are administered in a safe and timely manner, and as prescribed. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include:Checking identification band;Checking photograph attached to medical record; andIf necessary, verifying resident identification with other facility personnelThe individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Review of the clinical record indicated Resident R24 was admitted to the facility on [DATE].Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/7/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and history of falling.Review of a witness statement dated 11/5/25, completed by Registered Nurse (RN) Employee E4 stated, I was passing early morning meds on [NAME] Back and gave Resident R24 the roommate's insulin. When approaching the resident, she answered as the roommate's name and did not question the meds. Charge Nurse and physician notified. Orders given. Family notified at 6:45 a.m.Review of a witness statement dated 11/5/25, completed by RN Employee E5 stated, I was working with RN Employee E4 and she was on the back assisting with the morning meds. I went in to change another resident's colostomy bag. She [RN Employee E4] notified me that she had given meds to the wrong resident as the resident answered to the wrong name. Resident's blood sugar checked 146. Physician notified as well as the supervisor. Family notified. Orders given for IV (intravenous) dextrose, which was administered and running.During an interview on 11/21/25, at 10:45 a.m. the Director of Nursing (DON) stated Resident R25 was Resident R24's roommate at the time of the incident on 11/5/25.Review of physician orders revealed Resident R25 was ordered Lantus (a long-acting insulin) inject 20 units subcutaneously (beneath the skin into the fatty tissue layer) in the morning for DM (diabetes mellitus - a chronic metabolic disorder characterized by high blood sugar levels) at the time of the incident on 11/5/25.During an interview on 11/21/25, at 9:43 a.m. Licensed Practical Nurse (LPN) Employee E6 stated, During medication administration, I verify the right resident by asking their name, looking at the MAR (medication administration record), and look at their picture in their profile. If a resident is confused, I go by their picture. During an interview on 11/21/25, at 9:50 a.m. RN Employee E7 stated, During medication administration, I use the 5 rights, which is verifying right name, right route, right time, right med, and right dosage. If a resident is alert and oriented, I have them state their name and their date of birth and look at their picture in their profile. If a resident is confused, I verify them by the picture in their profile. During an interview on 11/21/25, at 9:55 a.m. RN Employee E8 stated, During medication administration, I verify a resident by their name and their picture in their profile.State Agency (SA) attempted to call RN Employee E4 to obtain a statement on 11/21/25, at 10:51 a.m. RN Employee E4 did not return a phone call to SA. During an interview on 11/21/25, at 11:58 a.m. the DON stated, RN Employee E4 verbally admitted to administering Resident R25's Lantus to Resident R24 and that is what she wrote in her witness statement. During an interview on 111/21/25, at 12:05 p.m. the DON confirmed that the facility failed to ensure that residents are free of significant medication errors for one of five residents reviewed (Resident R24). 28 Pa. Code: 201. 14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(5) Nursing services.