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	04/30/2026

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** Based on review of facility policy, facility documentation and clinical record, and resident and staff interviews, it was determined that the facility failed to ensure that one of two residents reviewed (Resident R1) was free of neglect during care which resulted in actual harm of a fracture of left femoral neck (hip fracture). This deficiency is cited as past non-compliance. Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed January 2026, indicated all reports of resident abuse (including injuries of unknown origins), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of Resident R1's admission record indicated that Resident R1 was admitted to the facility 3/15/23. Review of Resident R1's Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], indicated diagnoses of quadriplegia, gastroesophageal reflux disease (chronic condition where stomach acid flows back into the esophagus), and hyperlipidemia (condition that causes high levels of lipids, or fats, in the blood). Review of Section C: Cognitive Patterns indicated Resident R1 had a BIMS score of 15, cognitively intact. Review of Section GG - Functional Abilities - Mobility, Question GG0170A indicated the resident was coded at a 01 for dependent, helper does all of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident R1's Kardex (documentation system that allows nurses to organize and reference key patient information essential for their care plans) revealed Resident R1's bed mobility: x 2 assist. Review of Resident R1's care plan revealed a focus for ADL self-care performance deficit, initiated 4/3/25, updated 4/8/26 indicating Bed Mobility: assist x 2. Review of Resident R1's clinical record nursing progress note dated 4/1/26, at 3:23 p.m., revealed writer was alert by Nurse Aide that resident (R1) had slid off the side of her bed. Upon entering room resident (R1) was sitting on the floor, leaning with her back against nightstand and legs straight out and her head to the left, on a pillow against the mattress of her bed. Resident (R1) stated that she slid off her bed while Nurse Aide was providing care. Assessed no injuries. Redness to left upper back where she was leaning on nightstand. Assisted back to bed with hoyer lift and 3 staff. Resident (R1) complained of increased pain to left leg. Unit Manager present assisting with transfer back to bed. Notified physician services and confirmed orders for x-rays of the left leg. Notified resident (R1) and sister of fall and new orders. Further review of Resident R1's clinical record nursing progress note dated 4/2/26, at 12:11 a.m., revealed Resident (R1) transferred to hospital for evaluation and possible treatment related to post fall altered mental status, decreasing blood pressure, and increased heart rate. Resident (R1) transported via stretcher accompanied by two EMS (Emergency Medical Service) personnel. (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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(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	Appropriate parties aware including physician and supervisor. Further review of Resident R1's clinical record nursing progress note date 4/2/26, 4:15 a.m., revealed writer called hospital for an update on resident (R1), and nurse stated that resident (R1) was admitted to hospital for altered mental status and a left femoral neck fracture. Review of facility provided witness statement dated 4/1/26, revealed Resident R1 was interviewed by Unit Manager (UM) Employee E1 stating she (Resident R1) is unable to tell me what happened, other than she slipped off the bed. In a follow-up interview by UM Employee E1 with Resident R1 after Resident R1 was assessed and placed back into bed, indicated Resident R1 stated she (R1) slid between NA Employee E2 and the bed and she (R1) did not know how. She (R1) was insistent she did not hot her head but she (R1) was confused and seeing a man with a mustache carrying balloons. She (R1) was not able to clearly state what or how she rolled from the bed. Review of facility provided witness statement dated 4/1/26, provided by Nurse Aide (NA) Employee E2 stated I (NA Employee E2) was in (Resident R1's) room checking the resident. (NA Employee E2) was told another aide (NA) would be coming in shortly to assist me. (NA Employee E2) rolled the resident towards me and noted a bowel movement. (NA Employee E2) went to look behind me for a towel or other item to perform some degree of care whilst waiting for help. In that time, the resident (R1) slid off the bed in front of me in such a way where there was no way for me to catch her. (NA Employee E2) immediately scanned the resident (R1) for obvious wounds or bleeding before finding a nurse to do an assessment. During the fall, (NA Employee E2) did all (NA Employee E2) could to prevent it (rolling resident (R1) towards caregiver, actively looking for 2nd person to assist). Review of facility submitted investigation report dated 4/10/26, at 5:00 p.m., revealed upon investigation, it was determined that the assigned NA did not follow resident's (R1) Kardex instructions for required bed mobility assistance. The care plan indicated the need for additional support during transfers and repositioning. Failure to adhere to the established care plan directly contributed to the incident. The allegation was substantiated. During an interview on 4/30/26, at 1:35 p.m., Resident R1 revealed that she doesn't remember much about the incident other than she tried to make her head not hit her dresser and hit her hip instead. During an interview on 4/30/26, at 2:30 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that NA Employee E2 failed to provide appropriate bed mobility assistance to Resident R1 resulting in neglect during care. The facility failed to ensure that Resident R1 was free of neglect during care resulting in actual harm of a fracture of left femoral neck (hip fracture) due to providing improper bed mobility assistance. This deficiency is cited as past non-compliance. On 4/1/26, the facility initiated a plan of correction that included:The resident involved was immediately assessed following the incident, and appropriate medical evaluation and monitoring were conducted.The involved staff member received immediate re-education and corrective counseling on proper transfer techniques and strict adherence to care plans requiring two-person assistance. The incident was reviewed with nursing leadership to reinforce expectations regarding resident safety and compliance with care plans. Nursing staff have been re-educated on safe transfer procedures, including the requirement to wait for assistance when indicated in the care plan. Reinforcement of facility policy that prohibits single-person transfers when a two-person assist is required. Increased supervisory rounds by nursing leadership to ensure compliance with transfer protocols. Implementation of visual or care plan alerts (as applicable) to clearly identify residents requiring two-person assistance. Nursing supervisors/designee will conduct random audits of staff during transfers to ensure compliance.Audits will occur weekly for four weeks, then monthly thereafter, with results reported to the Quality Assurance and Performance Improvement (QAPI) Committee.Any observed noncompliance will result in immediate re-education and corrective action as appropriate. The facility was back in compliance on 4/22/26. Interviews with nine nurse aides confirmed they received education on bed mobility and location of communicated information specific to resident care. All staff interviewed acknowledged understanding of bed mobility education and where to find resident specific information related to assistance with care. During an interview on 4/30/26, at 2:30 p.m., the NHA and DON confirmed that the facility failed to ensure that one of two (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	residents reviewed (Resident R1) was free of neglect during care which resulted in actual harm of a fracture of left femoral neck (hip fracture). 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(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** Based on review of facility policy, clinical records, facility documentation, and resident and staff interviews, it was determined that the facility failed to provide adequate supervision and implement effective mobility interventions to promote resident safety, resulting in a preventable accident and actual harm when the resident received a fracture of the left femoral neck (hip fracture), for one of two residents reviewed (Resident R1). This deficiency is cited as past non-compliance. Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed January 2026, indicated all reports of resident abuse (including injuries of unknown origins), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of facility policy Resident Mobility and Range of Motion, last reviewed January 2026, indicated residents with limited mobility will receive appropriate care and services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.As part of the resident's comprehensive assessment, the nurse will identify the resident's:b. Current mobility status (per current MDS assessment tool), including his or her ability to:(1) Move to and from the lying position;(2) Turn and move side-to-side in bed;(3) Change body positions;(4) Transfer to and from bed or chair; and(5) Walk. Review of Resident R1's Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], indicated diagnoses of quadriplegia, gastroesophageal reflux disease (chronic condition where stomach acid flows back into the esophagus), and hyperlipidemia (condition that causes high levels of lipids, or fats, in the blood). Review of Section C: Cognitive Patterns indicated Resident R1 had a BIMS score of 15, cognitively intact. Review of Section GG - Functional Abilities - Mobility, Question GG0170A indicated the resident was coded at a 01 for dependent, helper does all of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident R1's Kardex (documentation system that allows nurses to organize and reference key patient information essential for their care plans) revealed Resident R1's bed mobility: x 2 assist. Review of Resident R1's care plan revealed a focus for ADL self-care performance deficit, initiated 4/3/25, updated 4/8/26 indicating Bed Mobility: assist x 2. Review of Resident R1's clinical record nursing progress note dated 4/1/26, at 3:23 p.m., revealed writer was alert by Nurse Aide that resident (R1) had slid off the side of her bed. Upon entering room resident (R1) was sitting on the floor, leaning with her back against nightstand and legs straight out and her head to the left, on a pillow against the mattress of her bed. Resident (R1) stated that she slid off her bed while Nurse Aide was providing care. Assessed no injuries. Redness to left upper back where she was leaning on nightstand. Assisted back to bed with hoyer lift and 3 staff. Resident (R1) complained of increased pain to left leg. Unit Manager present assisting with transfer back to bed. Notified physician services and confirmed orders for x-rays of the left leg. Notified resident (R1) and sister of fall and new orders. Further review of Resident R1's clinical record nursing progress note dated 4/2/26, at 12:11 a.m., revealed Resident (R1) transferred to hospital for evaluation and possible treatment related to post fall altered mental status, decreasing blood pressure, and increased heart rate. Resident (R1) transported via stretcher accompanied by two EMS (Emergency Medical Service) personnel. Appropriate parties aware including physician and supervisor. Further review of Resident R1's clinical record nursing progress note date 4/2/26, 4:15 a.m., revealed writer called hospital for an update on resident (R1), and nurse stated that resident (R1) was admitted to hospital for altered mental status and a left femoral neck fracture. Review of facility provided witness statement dated 4/1/26, revealed Resident R1 was interviewed by Unit Manager (UM) Employee E1 stating she (Resident R1) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	is unable to tell me what happened, other than she slipped off the bed. In a follow-up interview by UM Employee E1 with Resident R1 after Resident R1 was assessed and placed back into bed, indicated Resident R1 stated she (R1) slid between NA Employee E2 and the bed and she (R1) did not know how. She (R1) was insistent she did not hot her head but she (R1) was confused and seeing a man with a mustache carrying balloons. She (R1) was not able to clearly state what or how she rolled from the bed. Review of facility provided witness statement dated 4/1/26, provided by Nurse Aide (NA) Employee E2 stated I (NA Employee E2) was in (Resident R1's) room checking the resident. (NA Employee E2) was told another aide (NA) would be coming in shortly to assist me. (NA Employee E2) rolled the resident towards me and noted a bowel movement. (NA Employee E2) went to look behind me for a towel or other item to perform some degree of care whilst waiting for help. In that time, the resident (R1) slid off the bed in front of me in such a way where there was no way for me to catch her. (NA Employee E2) immediately scanned the resident (R1) for obvious wounds or bleeding before finding a nurse to do an assessment. During the fall, (NA Employee E2) did all (NA Employee E2) could to prevent it (rolling resident (R1) towards caregiver, actively looking for 2nd person to assist). Review of facility submitted investigation report dated 4/10/26, at 5:00 p.m., revealed upon investigation, it was determined that the assigned NA did not follow resident's (R1) Kardex instructions for required bed mobility assistance. The care plan indicated the need for additional support during transfers and repositioning. Failure to adhere to the established care plan directly contributed to the incident. The allegation was substantiated. During an interview on 4/30/26, at 1:35 p.m., Resident R1 revealed that she doesn't remember much about the incident other than she tried to make her head not hit her dresser and hit her hip instead. During an interview on 4/30/26, at 2:30 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that NA Employee E2 failed to provide adequate supervision and implement effective bed mobility interventions to promote resident safety for Resident R1, resulting in the resident receiving a hip fracture. The facility failed to ensure that Resident R1 was provided adequate supervision resulting in actual harm when the resident received a hip fracture, due to providing improper bed mobility assistance. This deficiency is cited as past non-compliance. On 4/1/26, the facility initiated a plan of correction that included:The resident involved was immediately assessed following the incident, and appropriate medical evaluation and monitoring were conducted.The involved staff member received immediate re-education and corrective counseling on proper transfer techniques and strict adherence to care plans requiring two-person assistance. The incident was reviewed with nursing leadership to reinforce expectations regarding resident safety and compliance with care plans. Nursing staff have been re-educated on safe transfer procedures, including the requirement to wait for assistance when indicated in the care plan. Reinforcement of facility policy that prohibits single-person transfers when a two-person assist is required. Increased supervisory rounds by nursing leadership to ensure compliance with transfer protocols. Implementation of visual or care plan alerts (as applicable) to clearly identify residents requiring two-person assistance. Nursing supervisors/designee will conduct random audits of staff during transfers to ensure compliance.Audits will occur weekly for four weeks, then monthly thereafter, with results reported to the Quality Assurance and Performance Improvement (QAPI) Committee.Any observed noncompliance will result in immediate re-education and corrective action as appropriate. The facility was back in compliance on 4/22/26. Interviews with nine nurse aides confirmed they received education on bed mobility and location of communicated information specific to resident care. All staff interviewed acknowledged understanding of bed mobility education and where to find resident specific information related to assistance with care. During an interview on 4/30/26, at 2:30 p.m., the NHA and DON confirmed that the facility failed to provide adequate supervision and implement effective mobility interventions to promote resident safety, resulting in harm when the resident received a hip fracture, for one of two residents reviewed (Resident R1). 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.