STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395861	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hrh Transitional Care Unit(A D/B/A Entity of Hrhs)	1648 Huntingdon Pike Meadowbrook, PA 19046

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assess residents for side rail use, review the risks and benefits of side rail use, and obtain informed consent from the resident or responsible party for use of side rails for four of nine sampled residents. (Resident 4, 36, 37, 38) Findings include: Clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that included arthritis and abnormalities of gait and mobility. A Minimum Data Set assessment completed January 21, 2026, revealed that the resident had no memory impairment and required moderate assistance of staff for bed mobility. On February 17, 2026, at 12:42 p.m., and 2:25 p.m., the resident was observed in bed with two side rails in the upright position. There was no documented evidence to support that an assessment was completed for side rail use, that the risk and benefits of side rail use were reviewed, or that informed consent was obtained from the resident or resident's responsible party prior to the use of the side rails. Clinical record review revealed that Resident 36 was admitted to the facility on [DATE], with diagnoses that included a right hip fracture. Clinical record documentation indicated that Resident 36 had no memory impairment and required supervisory assistance from staff for bed mobility. On February 17, 2026, at 2:22 p.m., and February 18, 2026, at 8:45 a.m., the resident was observed in bed with two side rails in the upright position. There was no documented evidence to support that an assessment was completed for side rail use or that the risk and benefits of side rail use were reviewed or that informed consent was obtained from the resident or resident's responsible party prior to the use of the side rails. Clinical record review revealed that Resident 37 was admitted to the facility on [DATE], with diagnoses that included a right thigh fracture. Clinical record documentation indicated that Resident 37 had no memory impairment and required supervisory assistance from staff for bed mobility. On February 18, 2026, at 8:33 a.m., the resident was observed in bed with two side rails in the upright position. There was no documented evidence to support that an assessment was completed for side rail use or that the risk and benefits of side rail use were reviewed or that informed consent was obtained from the resident or resident's responsible party prior to the use of the side rails. Clinical record review revealed that Resident 38 was admitted to the facility on [DATE], with diagnoses that included deconditioning. Clinical record documentation indicated that Resident 38 had no memory impairment and was independent for bed mobility. On February 17, 2026, at 2:24 p.m., and February 18, 2026, at 9:13 a.m., the resident was observed in bed with two side rails in the upright position. There was no documented evidence to support that an assessment was completed for side rail use or that the risk and benefits of side rail use was reviewed or that informed consent were obtained from the resident or resident's responsible party prior to the use of the side rails. In an interview on February 19, 2026, at 9:53 a.m., the Unit Manager confirmed there was no documented evidence to support that attempts to use alternative bed mobility methods were used, that the residents were assessed for bed rail use, and that informed consent discussing risks and benefits of bed rail use was obtained from the resident or resident's representative prior to bed rail use. 28 Pa 211.12(d)(1)(5) Nursing services.

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined the facility failed to notify the resident's representative(s) of transfer(s), including the reasons for the moves, in writing upon transfer for three of three residents who were transferred out of the facility (Residents 1, 5, and 29) and the facility failed to provide copies of the written discharge notices to a representative of the Office of the Long-Term Care Ombudsman for three of three residents who were discharged from the facility. (Residents 2, 3, and 31)Findings include: Clinical record review revealed that Resident 1 was transferred to the hospital on February 11, 2026, after a change in condition. There was no documented evidence to support that the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital.Clinical record review revealed that Resident 5 was transferred to the hospital on December 5, 2025, after a change in condition. There was no documented evidence to support that the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital.Clinical record review revealed that Resident 29 was transferred to the hospital on January 26, 2026, after a change in condition. There was no documented evidence to support that the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital.Clinical record review revealed that Resident 2 was discharged from the facility on February 5, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman.Clinical record review revealed that Resident 3 was discharged from the facility on January 30, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 31 was discharged from the facility on January 23, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman.In an interview on February 19, 2026, at 9:50 a.m., the Unit Manager confirmed that the notification of transfers were not sent for the noted resident representatives and that the written copies of the discharge notices were not sent to the Office of the State Long-Term Care Ombudsman.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(3) Management.