STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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. (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	Based on review of clinical records, the facility's abuse prohibition policy, facility investigative documentation, and interviews with staff and residents, it was determined that the facility failed to ensure that a resident was free from neglect by not providing care with the required assistance of two staff members as planned to ensure safety and prevent major injuries. As a result, one resident (Resident 1) sustained multiple subdural hematomas and a scalp laceration requiring hospitalization, representing actual harm for one resident out of one sampled for abuse prohibition.Findings include: Review of the facility's policy entitled Abuse, Neglect, and Exploitation last revised by the facility March 2025, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It is the policy of the facility to protect the residents from abuse, misappropriation of property, corporal punishment and involuntary seclusion. Resident 1's clinical record revealed admission to the facility on August 1, 2025, with diagnoses including atrial fibrillation (an irregular and often rapid heart rhythm that can lead to blood clots or stroke), a history of cerebral infarction (stroke), and hypertension (high blood pressure). Review of Resident 1's admission MDS assessment (Minimum Data Set a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 6, 2025, revealed the resident had a BIMS score of 00 (Brief Interview for Mental Status, a tool used to evaluate cognitive impairment and assist with dementia diagnosis. A score of 0-7 equates to severe cognitive impairment) and required assistance of staff for activities of daily living (ADL's). Review of Resident 1's current comprehensive person-centered care plan, initiated on August 5, 2025, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to confusion, musculoskeletal impairment and a history of stroke. Planned resident centered interventions revealed the resident required two-staff assistance with transfers to move between surfaces, required two-staff participation for bathing/showering and required assistance of one staff for bedpan use and brief changes, personal hygiene and oral care and eating. A review of a fall care plan for at risk for falls initiated August 5, 2025, revealed interventions to include, ensure that the resident is wearing appropriate footwear when ambulating and mobilizing in the wheelchair. Additionally, the resident's impaired cognitive function care plan indicated the resident had impaired cognition. A physician's order dated August 12, 2025, indicated Eliquis 2.5 mg twice daily for atrial fibrillation. Review of the August 2025 medication administration record showed the resident received Eliquis as prescribed through August 17, 2025. (Eliquis is an anticoagulant medication that increases bleeding risk.) A nurse's note written by Employee 1 (Registered Nurse), dated August 18, 2025, at 5:15 AM, documented that Employee 2 (nurse aide) exited Resident 1's room and stated, I need a nurse, Resident 1 is on the floor. Employee 2 reported transferring the resident from bed to wheelchair alone, despite the care plan requirement for two-staff assistance. She stated the bed alarm activated, and while she turned her back to silence it, Resident 1 fell forward out of the wheelchair, the nurse aide was unable to prevent the resident from falling. The RN found Resident 1 lying face-down on the floor, on the door side of her bed on her stomach with her head facing her bed, barefoot, and no nonskid socks in place, with the wheelchair near her feet. The resident had a large hematoma (collection of blood between layers of tissue) and a moderately bleeding forehead laceration (wound). A pressure dressing was applied Emergency services were contacted, and the resident was transported to the hospital for evaluation and treatment. Hospital records dated August 18, 2025, at 6:08 AM, documented that Resident 1 presented as a Level II trauma (requiring urgent trauma care) with head and knee pain. A CT scan (computed tomography imaging test that uses X-rays and a computer to get detailed images of an injury) of the head revealed multiple subdural hematomas (collections of blood between the brain and its protective covering), a small subarachnoid hemorrhage (bleeding between the brain and protective membranes), and a 3 cm forehead laceration. The resident was admitted to the Progressive Care Unit (unit in a hospital unit that provides a level of care between the general medical-surgical units and the Intensive Care Unit) for treatment and remained hospitalized until August 23, 2025. The CT results were as follows: The resident was diagnosed with a right superior tentorium hyperdense subdural hematoma. A subdural hematoma is bleeding that becomes trapped between the brain's surface and its tough outer covering, called the dura. The tentorium is a thick membrane inside the skull that separates the upper and lower parts of the brain. The term hyperdense means the bleeding is new or fresh and appears brighter on the CT scan, indicating recent injury. The scan further showed left anterior and right mid parafalcine hyperdense subdural hematomas