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	04/08/2026

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 - 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 clinical records, facility policy, investigative documentation provided by the facility, and staff interviews, the facility failed to protect one of 11 sampled residents (Resident CR1) from neglect when staff did not help a resident after a witnessed fall, leaving the resident on the floor, neglecting to immediately assess and care for the resident. This deficiency is cited as past noncompliance.Findings include: A review of a facility policy titled Abuse, Neglect, and Exploitation, last reviewed by the facility on April 8, 2025, revealed it is the facility's policy to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies that prohibit and prevent abuse and neglect. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish (severe emotional distress), or emotional distress. The policy indicated neglect includes withholding or inadequately providing care or services necessary to maintain resident safety and well-being. A review of the clinical record revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses including cerebral infarction (damage to brain tissue caused by loss of blood supply due to blockage of an artery) and a history of frequent falls. A physical therapy assessment dated [DATE], documented Resident CR1 required the use of a wheelchair for mobility. A review of progress notes revealed the resident experienced multiple behavioral symptoms from admission through discharge, including confusion, hallucinations (perceiving things that are not present), verbal outbursts, and episodes of aggression toward staff. A review of CR1's clinical record revealed a physical therapy assessment completed on March 13, 2026, documented resident CR1 was able to mobilize with the assistance of a wheelchair. A review of Resident CR1's progress notes revealed the resident experienced a fall on March 13, 2026, at 8:51AM, where the resident was observed standing from his wheelchair without assistance. The resident did not experience any injury at the time of the incident. The clinical record revealed Resident CR1 had frequent outbursts, and behavioral issues, with a documented incident on March 14, 2026, when the resident was observed to be gripping a nurse aides' wrist, yelling profanities at the employee. The clinical record revealed from the time of admission to the time of discharge Resident CR1 had multiple behavioral outbursts including yelling at staff, hallucinations, and episodes of confusion. A nursing progress note dated March 16, 2026, at 5:05 AM documented Resident CR1 frequently ambulated without assistance despite requiring a wheelchair for mobility. The note documented that the resident intermittently refused to remain seated and attempted to exit through doors. The note further documented the resident spoke about generals and colonels related to his history of being at war, and was aggressive to staff, stating staff are controlling him. A nursing progress note dated March 16, 2026, at 5:30 AM documented Resident CR1 fell after self-propelling in the wheelchair and was assisted back into the chair with no injury observed. A nursing progress note dated March 17, 2026, at 3:04 AM documented Resident CR1 attempted to stand from the wheelchair when the wheelchair rolled backward, resulting in the resident falling to the right side. A review of facility investigative documentation revealed an email dated March 19, 2026, at 3:50 AM from Employee 1 (Nurse Aide) to the Director of Nursing (DON) (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

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	04/08/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	reported Resident CR1 experienced two falls on March 17, 2026. The email documented that Employee 3 (Registered Nurse Supervisor) and Employee 4 (Licensed Practical Nurse) were aware of the second fall and instructed staff that no incident report or witness statements were required. The email documented staff were instructed to allow the resident to remain on the floor because he could get up on his own. Employee 1 wrote that she forgot to make the DON aware of the incident sooner. An interview with the DON on April 8, 2026, at 9:30 AM revealed the facility initiated an investigation immediately upon receipt of the email reporting concerns that staff did not report the second fall and allegedly indicated Employee 3 (Registered Nurse Supervisor) advised staff to allow the resident to remain on the floor after the fall. A review of employee witness statements revealed Employee 2 (Nurse Aide) documented she witnessed Resident CR1 on the floor and assisted the resident back to his wheelchair. Employee 2 (Nurse Aide) wrote she then witnessed the resident on the floor a second time but was told by Employee 3 (Registered Nurse Supervisor) that the resident could get up on his own. Employee 2 (Nurse Aide) documented that Resident CR1 was observed crawling on the floor. Employee 2 (Nurse Aide) wrote she asked Employee 3 (Registered Nurse Supervisor) if a witness statement was needed regarding the details of the fall, and Employee 3 (Registered Nurse Supervisor) responded, no. A review of a written witness statement from Employee 3 (Registered Nurse Supervisor) dated March 19, 2026, documented that on March 17, 2026, at 2:50 AM, the resident was observed to fall after attempting to stand from his wheelchair. Employee 3 (Registered Nurse Supervisor) wrote she assisted the resident back to a seated position in the wheelchair and assessed him for injuries. Employee 3 (Registered Nurse Supervisor) documented that 10 to 15 minutes later, Resident CR1 rose from the wheelchair to a standing position, lost his balance, and was observed to fall again. Employee 3 (Registered Nurse Supervisor) wrote the resident was crawling on the floor and was asked if he was ready to get up, to which Resident CR1 responded no. Employee 3 (Registered Nurse Supervisor) documented that due to the resident's history of combative behavior (combative behavior means the resident may physically resist care, such as hitting, grabbing, or pushing staff), she did not assist the resident to a standing position until the resident verbalized he was ready to return to his wheelchair. A phone interview with Employee 4 (Licensed Practical Nurse) on April 8, 2026, at 9:38 AM, revealed she was working in the area of the second fall but did not witness the fall occur. Employee 4 (Licensed Practical Nurse) stated she went to the nurse's station when Employee 3 (Registered Nurse Supervisor) stated, Guess who is on the floor again. Employee 4 (Licensed Practical Nurse) stated she asked Employee 3 (Registered Nurse Supervisor) if staff should assist the resident up, and Employee 3 (Registered Nurse Supervisor) stated, No, He will just throw himself on the ground again. Employee 4 (Licensed Practical Nurse) confirmed she did not report the fall or write a witness statement regarding the incident. Employee 4 (Licensed Practical Nurse) stated she was under the impression that Employee 3 (Registered Nurse Supervisor), who was the supervisor on duty, would report the incident. A phone interview with Employee 3 (Registered Nurse Supervisor) on April 8, 2026, at 11:05 AM, revealed Employee 3 (Registered Nurse Supervisor) believed she was helping the resident by allowing him to remain on the floor. Employee 3 (Registered Nurse Supervisor) stated the resident appeared to be acting as though he was fixing something on the wheelchair, and she feared he would become combative if she attempted to assist him to stand. Employee 3 (Registered Nurse Supervisor) stated she remained nearby and observed the resident until he indicated he was ready to get up. Employee 3 (Registered Nurse Supervisor) stated that at no time was the resident left alone but was unable to determine the length of time the resident remained on the floor following the fall. Employee 3 (Registered Nurse Supervisor) stated she did not report the second fall to the Director of Nursing because the first and second falls occurred close together in time. Attempts to contact Employee 1 Nurse Aide and Employee 2 Nurse Aide on April 8, 2026, were unsuccessful. A review of Employee 3's personnel file revealed documentation dated January 6, 2026, confirming completion of orientation training, which included education regarding the facility's abuse and neglect policy and required reporting procedures. During an interview on April 8, 2026, at 12:45 (continued on next page)

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	04/08/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	PM, the Director of Nursing and Nursing Home Administrator confirmed the facility investigation determined Employee 3 (Registered Nurse Supervisor) and Employee 4 (Licensed Practical Nurse) did not follow the facility's abuse and neglect policy related to resident protection and reporting requirements and failed to provide timely assistance after a witnessed fall inconsistent with accepted standards of practice reflecting neglect. The Director of Nursing and Nursing Home Administrator confirmed Employee 3 and Employee 4 were removed from the work schedule immediately pending investigation and were subsequently terminated. The deficient practice was cited as past noncompliance; The facility implemented the following corrective actions immediately following the incident. The resident was assessed for any injury. Employee 3 and Employee 4 were immediately terminated.The facility completed an audit on residents who had documented falls within the last 30 days and conducted interviews to determine the prompt response time to the incident and the behavior of the staff during these incidents.The facility immediately conducted facility wide education on the abuse/neglect policy.To sustain compliance, the facility administration initiated a plan to conduct five random audits regarding staff reporting, these audits scheduled weekly for one week, bi-weekly for two weeks, and weekly for one month.The results of the audits are to be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) Committee for oversight and recommendations. The facility achieved compliance with this regulatory requirement on March 23, 2026. This deficiency is cited as past noncompliance. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.