STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395003	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - New Castle	520 Friendship Street New Castle, PA 16101

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on a review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make accessible grievance forms, and access to the grievance box by wheelchair dependent residents to enable filing grievances anonymously in the main entrance.Findings include: Review of a facility policy entitled Communication of Resident, Family and Staff Concerns and Grievances Article VIII dated 1/13/26 indicated that the facility will encourage residents to communicate a concern or grievance verbally or by completing a Concern Form independently and/or with assistance; forms can be obtained by contacting the Administrator (NHA), Director of Nursing (DON), or Social Services Director (SSD); and forms are located at any nurse's station. Interview with Resident Council members on 5/19/26, from 11:00 a.m. to 12:00 p.m. confirmed that they do not know where the grievance box is or how to get forms to file a concern anonymously. Observation on 5/19/26, at 12:04 p.m. of the grievance box located at the front entrance of the building revealed there were no accessible grievance forms located near the box, and that a wheelchair bound resident (when asked to do so) could not deposit a form into the top opening of the Grievance box without assistance. During an interview with the Nursing Home Administrator at that time, confirmed that residents can retrieve a grievance form from the NHA, DON, SSD, or any nurse at the nurse's station. The NHA also confirmed that being required to request a form from staff did not maintain the anonymity of filing a confidential grievance. 28 Pa. Code 201.18 (b)(1)(2)(3) Management28 Pa. Code 211.10 (c) Resident Care Policies

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), upon or within twenty-four hours of transfer for two of eight residents reviewed for hospitalization (Residents R2 and R9) and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for six of eight residents reviewed for hospitalization (Residents R2, R8, R9, R11, R118, and Closed Record CR147). Findings include: Facility policy entitled Notice of Bed-Hold Policy for a Hospitalization or Therapeutic Leave dated 1/13/26, revealed that during a hospitalization or therapeutic leave the resident will be offered the opportunity to reserve their residency. It further revealed that depending on how the residents stay is financed determines how they are affected and they are asked to sign and date the notice and return it to the facility. Facility policy entitled Transfer of Resident to Another Care Community dated 1/13/26, revealed that the facility will copy and prepare documents needed for transfer to promote continuity of care including, but not limited to Face Sheet, Advanced Directive / POLST, Physician Orders, Medication Administration Record, Diagnosis, History and Physical, Scheduled appointments, Recent Lab Work and other information as requested. Resident R2's clinical record revealed an admission date of 9/23/22, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), Gastrostomy Tube (a surgical incision is made through the abdomen wall and into the stomach to insert a tube to provide feedings through when a person cannot take food or liquids by mouth), and Dementia (loss of cognitive functioning affecting a person's memory and behaviors). Resident R2's progress notes revealed a note dated 12/30/25, indicating a transfer to the hospital. The clinical record lacked evidence that Resident R2 and/or his/her representative were provided with a copy of the facility bed-hold policy and that his/her necessary clinical information was communicated to the receiving health care provider. Progress note dated 2/21/26, revealed a transfer to the hospital. The clinical record lacked evidence that Resident R2's necessary clinical information was communicated to the receiving health care provider. Progress note dated 2/28/26, indicated a transfer to the hospital. The clinical record lacked evidence that Resident R2 and/or his/her representative were provided with a copy of the facility bed-hold policy and that his/her necessary clinical information was communicated to the receiving health care provider. Resident R8's clinical record revealed an admission date of 2/20/26, with diagnoses that included Chronic Kidney Disease (a long-term condition in which the kidneys are damaged and gradually lose their ability to function properly over time, gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure. Review of Resident R8's progress notes revealed a note dated 2/24/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R9's clinical record revealed an admission date of 6/23/23, with diagnoses that included Sepsis (a reaction to an infection that causes extensive inflammation throughout the body, potentially leading to tissue damage, organ failure, and even death), Neurogenic Bladder (when the nerves or the brain cannot communicate effectively to the muscles in the bladder), and Anemia (a reduction in red blood cells resulting in symptoms such as fatigue and weakness). Resident R9's progress notes revealed notes dated 10/18/25, and 1/15/26, indicating a transfer to the hospital. The clinical record lacked evidence that Resident R9 and/or his/her representative were provided with a copy of the facility bed-hold policy. Another progress note dated 2/20/26, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving health care provider. Resident R11's clinical record revealed an admission date of 2/10/26, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Congestive Heart Failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply causing blood and fluids collect in your lungs and legs over time), and A-Fib. Resident R11's progress notes revealed a note dated 2/20/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R118's clinical record revealed an admission date of 2/9/26, with diagnoses that include Chronic Kidney Disease, Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and high blood pressure. Resident R118's progress notes revealed a note dated 2/21/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 5/21/26, at 9:28 a.m. the Nursing Home Administrator (NHA) confirmed that Residents R2 and R9's clinical record lacked evidence that the facility provided the resident and/or resident representative with a written notice of the facility bed-hold policy upon or within twenty-four hours of transfer and that Residents R2, R8, R9, R11, and R118's clinical records lacked evidence that the necessary clinical information was provided to the receiving health care provider. Resident CR147's clinical record revealed an admission date of 4/18/26, with diagnoses that included Cerebral Infarction (a condition where a part of the brain is damaged or dies due to a lack of blood supply), Diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident CR147's progress notes revealed a note dated 5/2/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 5/21/26, at 12:30 p.m. the NHA confirmed that Resident CR147's clinical record lacked evidence that the necessary clinical information was provided to the receiving healthcare provider. He/she also confirmed when the transfer occurred clinical information should have been provided to the receiving healthcare provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff and resident interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for seven of 30 residents (Residents R7, R24, R31, R41, R75, R87, and R155).Findings include: Facility policy entitled, Oxygen Concentrator [medical device that extracts oxygen from the surrounding air, filters it, and delivers oxygen-enriched air to patients with low blood oxygen levels] dated 1/13/26, indicated to change the water bottle weekly, or more if needed; clean the outside of the concentrator with disinfectant when it becomes soiled; after a concentrator is discontinued, place the equipment in the soiled utility room. Facility policy entitled, Oxygen Therapy via Nasal Cannula-NU14.7 dated 1/13/26, indicated that the nasal cannula [NC- thin, lightweight, and flexible tube that splits into two small prongs inserted into the nostrils, allowing oxygen or a mixture of air and oxygen to flow directly into the respiratory system] will be replaced every seven days, date and store in a plastic bag when not in use. Facility policy entitled, Small Volume Nebulizer (SVN)-NU14.12 dated 1/13/26, indicated to rinse the SVN mouthpiece and T piece with tap water and dry with paper towel; ensure equipment is dry, not damp, and place in storage bag labeled with the resident's name and date equipment was used; replace equipment every seven days; date connecting tubing; and replace the connecting tubing every seven days. Resident R7's clinical record revealed an admission date of 1/25/24, with diagnoses including encounter for palliative care [specialized medical care focused on improving quality of life and relieving symptoms for people with serious illnesses], dementia, kidney disease, heart failure, and Type 2 Diabetes [happens when the body cannot use insulin correctly and sugar builds up in the blood]. Resident R7's clinical record contained a physician's order dated 3/31/26, to administer DuoNeb solution via nebulizer [medical device that converts liquid medication into a fine mist that can be inhaled directly into the lungs] every six hours. Observation on 5/18/26, at 2:30 p.m. revealed Resident R7's nebulizer mask dated 5/11/26, lying on the bedside stand and was not stored in a plastic bag. Resident R24's clinical record revealed an admission date of 11/20/24, with diagnoses including chronic obstructive pulmonary disease [COPD- common lung disease causing restricted airflow and breathing problems], depression, shortness of breath, suicide attempt, and anxiety. Resident R24's clinical record revealed a physician's order dated 3/16/26, to apply supplemental oxygen at two liters per minute [lpm] as needed. Observation on 5/18/26, at 2:40 p.m. revealed Resident R24's oxygen tubing with NC lying across his/her bed and was not stored in a plastic bag. Resident R31's clinical record revealed an admission date of 10/18/17, with diagnoses including respiratory failure, COPD, heart failure, and pleural effusion [build-up of fluid around the lungs constricting air flow. Resident R31's clinical record revealed a physician's order dated 5/14/26, to apply supplemental oxygen at two lpm via NC continuously, and a physician's order dated 5/13/26, to administer DuoNeb solution via nebulizer twice daily. Observation on 5/18/26, at 2:45 p.m. revealed Resident R31's nebulizer mask lying on the bedside table, and his/her supplemental oxygen tubing with NC lying on the seat of his/her wheelchair and was not stored in a plastic bag. Resident R41's clinical record revealed an admission date of 8/11/25, with diagnoses including COPD, irregular heartbeat, heart failure, and respiratory failure. Resident R41's clinical record revealed a physician's order dated 4/10/26, to apply supplemental oxygen at three lpm via NC continuously at bedtime. Observation on 5/18/26, at 1:51 p.m. revealed Resident R41's oxygen tubing with NC lying over the top of the concentrator was not stored in a plastic bag. Resident R75's clinical record revealed an admission date of 2/25/25, with diagnoses including COPD, irregular heartbeat, dementia, and atherosclerotic heart disease [hardening of the arteries due to plaque buildup]. Resident R75's clinical record revealed a physician's order dated 3/13/26, to apply supplemental oxygen as needed to keep oxygen saturation above or equal to 92%. Review of Resident R75's Treatment Administration Record revealed the most recent documented use of his/her supplemental oxygen was 11/11/25. Observation on 5/18/26, at (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2:05 p.m. revealed Resident R75's oxygen tubing dated 1/26/26, lying over the top of the concentrator, the humidifier bottle empty, and the concentrator cannister covered in a layer of dust. During an interview at that time, Resident R75 confirmed that he/she used oxygen when they first arrived but had not used oxygen in a very long time. Resident R87's clinical record revealed an admission date of 6/10/24, with diagnoses including COPD, heart failure, atherosclerotic heart disease, and peripheral vascular disease [arteries in your legs, pelvic area or arms become narrowed or blocked, usually due to plaque buildup]. Resident R87's clinical record revealed a physician's order dated 3/16/26, to apply supplemental oxygen at one-two lpm via NC as needed. Observation on 5/18/26, at 2:40 p.m. revealed Resident R87's oxygen tubing with NC lying on top of the concentrator, dated 5/11/26, and was not stored in a plastic bag. The external oxygen concentrator cannister was covered with a layer of dust; and the humidifier bottle was empty. Resident R155's clinical record revealed an admission date 5/15/26, with diagnoses including COPD, stroke, atherosclerotic heart disease, and sleep apnea. Resident R155's clinical record revealed a physician's order dated 5/15/26, to administer Ipratropium Bromide [relaxes bronchioles to prevent spasms] four times daily. Observation on 5/18/26, revealed Resident R155's nebulizer mask lying on his/her bed and was not dated or stored in a plastic bag. During an interview on 5/18/26, between 3:10 p.m. and 3:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the above mentioned nebulizer and oxygen equipment was not changed timely and that the equipment should have stored in a plastic bag when not in use, and that Resident R75's oxygen concentrator and tubing should have been removed from the room, cleansed and placed in storage. 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to discard of and properly label after opening multi-dose insulin (medication to treat elevated blood sugar levels) pens with the date it was opened, and failed to discard of one multi dose insulin pen and one [NAME] dose vial of Tubersol (an injectable diagnostic solution test to determine if a person has been infected with tuberculosis) in two of four medication carts (2 west cart 2, east 2 cart 2) and one of two medication storage rooms reviewed (East Med storage room). Findings include: A facility policy entitled Medication storage in the facility last reviewed 1/13/26, revealed drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is in a multi-dose injectable vial or an item for which the manufacturer has specified a usable life after opening. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. An observation on 5/18/26, at approximately 2:00 p.m., of the 2 [NAME] nursing unit Cart 2 revealed one insulin Solostar pen opened and in the drawer for use not dated with an opened or use by date. Licensed Practical Nurse (LPN) Employee E3 confirmed that the pen should be dated after opened for use with open and use by date. An observation on 5/18/26, at approximately 2:39 p.m., of the 2 East nursing unit Cart 2 revealed one insulin multi dose vial opened and in the drawer for use labeled with an opened date of 4/19/26 and a use by date labeled 5/17/26 . LPN Employee E4 confirmed that the pen should be discarded and not in the drawer for use since it was past the use by date of 5/17/26. An observation on 5/18/26, at approximately 2:20 p.m., of the East unit medication storage room revealed one multi dose vial of Tubersol opened and in refrigerator for use labeled with an opened date of 3/21/26 and no use by date labeled. LPN Employee E2 confirmed that the multi-use vial should be discarded and not in the drawer for use since it was past 30 days of the open date. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1) Nursing services

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Food Committee and Resident Council minutes, and resident and staff interviews, it was determined that the facility failed to respond to resident concerns identified during Resident Council and Food Committee minutes for three months reviewed (February 2026, March 2026, and April 2026).Findings include: Review of the 2/24/26, Food Committee meeting minutes revealed residents reported they are not receiving their snacks in the evening and requested that the snack cart be left by the nurse's station. There was no evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.Review of the 3/03/26, Food Committee meeting minutes revealed residents reported they are not receiving snacks, staff are not in the dining room to pass trays, they would like condiment packets (hot sauce, honey mustard, ranch) and they would like less fish on the menu. There was no evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.Review of the 4/28/26, Food Committee meeting minutes revealed residents reported they continue to have a problem with snacks and would like to have fish only once per month. There was no evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.Review of the 2/24/26, Resident Council meeting minutes for new business revealed that the last month's meeting notes were reviewed, residents requested to keep the hallways clear for better mobility, and residents would like increased rounds by Nurse Aides on the 2 [NAME] Unit. There was no evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.Review of the 4/09/26, Resident Council meeting minutes revealed residents reported that snacks are not being distributed and are not always available, snacks are left by the nurse's station and not offered to residents, an ongoing concern about dining room staffing, and smoking in the dock area. There was no evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.Review of the 4/28/26, Resident Council meeting minutes lacked evidence that concerns and/or resolutions of concerns from the previous meeting were discussed.During an interview on 5/19/26, at 11:00 a.m. Resident Council Members confirmed that resident concerns from previous meetings are not being reviewed regarding what attempts were made to resolve the concerns and/or by whom, and if they are satisfied with the resolution of their concerns, snacks are still not being passed, they are still getting fish, and are not receiving condiments on their meal trays.During an interview on 5/19/26, at 3:30 p.m. the Nursing Home Administrator and Social Worker confirmed there was no evidence that facility staff provided the Resident Council and Food Committee with responses, actions, and rationale taken regarding their concerns.During an interview on 5/20/26, at 10:00 a.m. the Activities Director confirmed that he/she does review the concerns with the Resident Council President prior to the next meeting, however has no evidence that responses, actions, and rationale taken regarding their concerns were presented to the Resident Council and Food Committee.28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 201.18(e)(1)(4) Management

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of an as needed (PRN) psychotropic (mind altering) medication beyond 14 days for one of five residents reviewed for unnecessary medications (Resident R6).Findings include: Resident R6's clinical record revealed an admission date of 10/14/25, with diagnoses including Type 2 Diabetes [happens when the body cannot use insulin correctly and sugar builds up in the blood], Charcot's Joint-ankle and foot [degenerative joint disorder characterized by the progressive destruction of the joint], heart failure, and chronic obstructive pulmonary disease [COPD- common lung disease causing restricted airflow and breathing problems]. Resident R6's clinical record revealed a physician's order to administer hydroxyzine (anti-anxiety medication) 25 milligrams (mg) by mouth every eight hours as needed dated 10/14/25 and discontinued on 3/17/26. Review of Resident R6's Medication Administration Record (MAR) revealed he/she received the hydroxyzine twice on 12/28/25. Resident R6's clinical record revealed a physician's order to administer hydroxyzine 25 mg by mouth every eight hours as needed dated 3/17/26 and discontinued on 4/22/26. Review of Resident R6's Medication Administration Record (MAR) revealed he/she received the hydroxyzine on 3/22/26, and 4/15/26. Review of Resident R6's current physician's orders revealed an order dated 4/22/26, with a discontinue date of 10/22/26, to administer hydroxyzine 25 mg by mouth every eight hours as needed. Interview on 5/21/26, at 12:06 p.m. with the Director of Nursing confirmed that Resident R6's hydroxyzine lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for one of 30 residents reviewed (Resident R5) and failed to ensure that the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan for one of 30 residents reviewed (Resident R136). Findings include: Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for one of 30 residents reviewed (Resident R5) and failed to ensure that the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan for one of 30 residents reviewed (Resident R136). Findings include: Facility policy dated 1/13/26, entitled Comprehensive Care Plan revealed that based on information generated by the comprehensive assessment staff will develop an individualized care plan and that the care plan is updated as needed due to condition changes, goals being met, interventions ineffective. Resident R5's clinical record revealed an admission date of 1/13/24, with diagnoses that included Diabetes (a health condition caused by the body's inability to produce enough insulin), End Stage renal Disease (ESRD - when the kidneys have permanently lost their ability to function effectively. A person typically requires regular dialysis or a kidney transplant to survive), and High Blood Pressure. Resident R5's physician orders dated 12/26/25, revealed Discontinue Indwelling Catheter. Resident R5's Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care) with an Assessment Reference Date (ARD) of 3/16/26, Section H0100 Appliances Subsection A Indwelling Catheter (including suprapubic catheter and nephrostomy tube) was coded as No. Resident R5's care plan revealed a care plan with an initiated date of 1/6/25, revision date of 3/15/26, and target date of 6/10/26, with a goal I have an indwelling catheter r/t disease process - Kidney Failure. During an interview on 5/21/26, at 11:12 a.m. the Director of Nursing (DON) confirmed that Resident R5's clinical record revealed an active care plan for an indwelling catheter. The DON further confirmed the care plan should have been updated to reflect the indwelling catheter being discontinued on 12/26/25. Resident R136's clinical record revealed an admission date of 2/26/26, with diagnoses that included dementia (a decline in cognitive abilities such as memory, reasoning, and communication-that is severe enough to interfere with daily life), weight loss, muscle weakness, and anxiety. A facility policy dated 1/13/26, entitled Initial Care Conferences revealed that resident's caregivers are invited to attend the care conference. The home will call the resident representative if the representative does not accompany the resident to the home as part of the admission process. Involvement of the family and the resident provides for a much more streamlined process. During an interview with R136's representative on 5/18/26, at 12:30 p.m. he/she revealed that he/she had not attended the 3/12/26 care plan meeting nor did he/she recall being invited to the 3/12/26 care plan meeting. During an interview on 5/21/26, at 11:35 a.m. Social Worker confirmed the clinical record lacked evidence of the resident representative being informed or invited to Resident R136's care plan meeting held 3/12/26. During an interview on 5/21/26, at 11:50 a.m. Nursing Home Administrator (NHA) confirmed the facility could not provide proof that Resident R136 and his/her representative was invited to the care plan meeting and they should have been. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies

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	395003	A. Building B. Wing	05/21/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of the hospice/facility agreement and clinical records, and staff interview, it was determined that the facility failed to maintain current information related to Hospice services for one of 23 residents reviewed (Resident R7).Findings include: Review of the Nursing Facility Hospice Services Agreement dated 8/29/19, indicated that the Nursing Facility and Hospice shall each prepare and maintain complete, accurate, and detailed clinical records concerning each resident/patient; all entries made for services provided are to be legible, clear, complete; and each such record shall be readily available on request by an authorized federal, state, of local government or regulatory agency. Resident R7's clinical record revealed an admission date of 1/25/24, with diagnoses including encounter for palliative care [specialized medical care focused on improving quality of life and relieving symptoms for people with serious illnesses], dementia, kidney disease, heart failure, and Type 2 Diabetes [happens when the body cannot use insulin correctly and sugar builds up in the blood]. A physician's order dated 3/13/26, indicated that Resident R7 was admitted to hospice services effective 12/26/25. Further review of Resident R7's clinical record revealed the most recent Hospice communication/record of all services furnished to the resident was dated 4/14/26. During an interview on 5/20/26, at 9:20 a.m. the Nursing Home Administrator confirmed the most recent Hospice communication was dated 4/17/26, documentation regarding Resident R7's Hospice services was not complete, current or available to the survey team, and that more recent communication records should have been available. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to serve food in a safe and sanitary manner during tray line and ensure that food was stored in accordance with standards for food safety in two of three resident pantries checked (1 [NAME] and East Wing pantries).Findings include: Review of a facility policy entitled Food Safety and Sanitation dated 1/13/26, revealed All local, state and federal standards and regulations are followed in order to assure a safe and sanitary food service department; Hair restraints are required and should cover all hair on the head; beard nets are required when beard is longer than .5 inches or untrimmed; Food with expiration dates are used prior to the use by date on the package. Review of a facility policy entitled Food Brought in From Outside Sources dated 1/13/26, revealed Food brought in from family and visitors will be stored in the refrigerators located on each unit; Items brought into the facility must be labeled with the resident name and the date it was prepared ;Condiment-type foods may be kept for 2 months/60 days or until factory marked date, whichever is first; Leftover foods are to be kept for five days following the date of preparation. The day of preparation is day one. Observations during tray line on 5/18/26, at 12:58 p.m. revealed a dietary aide carrying resident food trays not wearing a hair net or beard net/restraint. During an interview on 5/18/26, at time of observation, the Dietary Manager confirmed that the dietary aide was not wearing a hair net and beard net/restraint during tray line while handling resident food. He/she further confirmed that the dietary aide should be wearing a hair net and beard net/restraint while in the dietary department. Observations on 5/18/26, at 2:55 p.m. of the 1 [NAME] pantry refrigerator used for residents revealed containers of honey thick apple juice with use by dates of 2/27/26 and 2/24/26, containers of dairy drink with best used by date of 1/15/26, a box of pizza without a resident name or date, and several ice packs used for resident care stored next to resident food. During an interview on 5/18/26, at the time of the observation, Licensed Practical Nurse (LPN) Employee E3 confirmed that the refrigerator contained expired food, resident food without a resident name or date, and ice packs beside resident food. He/she also confirmed that the juice and milk items should have been discarded by their expiration date, the pizza box should have a resident name and date, and that ice packs that are used on resident's bodies should not be stored in the resident refrigerator with food. Observations on 5/19/26, at 2:00 p.m. of the East Wing pantry freezer used for residents revealed a bag of frozen broccoli with a resident name and expiration date of 12/14/25, and two ice packs used for resident care stored next to resident food. During an interview on 5/19/26, at the time of observation, Certified Nursing Assistant (CNA) Employee E1 confirmed that the bag of broccoli was expired, and the ice packs were in the freezer with food. He/she further confirmed that the bag of broccoli should be discarded and that ice packs used for treatments should not be stored with food. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during a dressing change for one of two residents with pressure ulcers requiring wound care reviewed (Resident R5). Findings include: Facility policy entitled Enhanced Barrier Precautions dated 1/13/26, revealed EBP are utilized to prevent the spread of multi-drug organisms to residents. Policy further revealed that gloves and gowns are applied prior to performing the high contact resident care activities, which includes wound care. Resident R5's clinical record revealed an admission date of 1/13/24, with diagnoses that included Diabetes (a health condition caused by the body's inability to produce enough insulin), End Stage renal Disease (ESRD - when the kidneys have permanently lost their ability to function effectively. A person typically requires regular dialysis or a kidney transplant to survive), and High Blood Pressure. Resident R5's clinical record revealed a physician's order dated 3/12/26 for Enhanced Barrier Precautions every shift. Observation of wound care on 5/18/26, at approximately 2:40 p.m. revealed signage on Resident R5's door indicating EBP and usage of gown and gloves required. Licensed Practical Nurse (LPN) Employee E2 entered Resident R5's room and completed wound care without putting a gown on. During an interview on 5/18/26, at 2:49 p.m. LPN Employee E2 confirmed he/she did not put on a gown prior to entering Resident R5's room or prior to completing wound care. LPN Employee E2 stated he/she was not sure if they were required to wear a gown, as it was not clear. During an interview on 5/18/26, at 3:00 p.m. the Nursing Home Administrator confirmed that LPN Employee E2 should have put on a gown prior to entering Resident R5's room for wound care as facility policy and signage indicate. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing service

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and staff interview, it was determined that the facility failed to ensure that the required nursing staffing information was posted on a daily basis.Findings include: Observations on 5/19/26, at 10:25 a.m. revealed that the daily staffing posting was not publicly posted in the facility. During interview at the time of the observation, the lack of the posting was confirmed by the Nursing Home Administrator. 28 Pa. Code 201.14 (a) Responsibility of Licensee

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records, facility documentation, facility policies, and staff interview, it was determined that the facility failed to maintain complete and accurate records for six of 31 residents (Residents R3, R19, R59, R87, R114 and Closed Record CR150).Findings include: Review of facility policy entitled Admission dated 1/13/26, revealed that staff will complete an inventory of all belongings; document on the inventory form; sign and date the form; have resident/family sign. Review of facility policy entitled, Care of Resident's Belongings dated 1/13/26, revealed that an inventory of personal effects will be completed when the resident is admitted to the care community, transferred or discharged ; be completed by nursing staff with the assistance of the resident or family; and that it must be signed by two people. A facility document located in the inventory binder at the nurse's station and provided by the facility on 5/20/26, indicated that social services will check for completion the next working day after admission. Resident R3's clinical record revealed an admission date of 6/25/21, with diagnoses including morbid obesity [complex chronic condition of a severe amount of body fat that can lead to several serious health issues], heart failure, irregular heartbeat, and pressure ulcer of the lower back. Resident R3's inventory of personal effects sheet dated 11/03/25, lacked evidence of resident and staff signatures. Resident R19's clinical record revealed an admission date of 3/09/23, with diagnoses including kidney disease, heart disease, respiratory failure, and seizures. Resident R19's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident R59's clinical record revealed an admission date of 3/22/19, with diagnoses including angina [chest pain or discomfort caused by reduced blood flow to the heart], irregular heartbeat, heart failure, and kidney disease. Resident R59's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident R87's clinical record revealed an admission date of 6/10/24, with diagnoses including chronic obstructive pulmonary disease [COPD- common lung disease causing restricted airflow and breathing problems], heart failure, sleep apnea, and kidney disease. Resident R87's inventory of personal effects sheet dated 6/10/24, lacked evidence of staff signatures. Resident R114's clinical record revealed an admission date of 10/27/16, with diagnoses including lung cancer, COPD, Rheumatoid arthritis [the immune system mistakenly attacks the body's own tissues, causing pain, swelling, and stiffness to the joints], and epilepsy. Resident R114's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident CR150's clinical record revealed an admission date of 12/27/25, with diagnoses that included Protein Calorie Malnutrition (occurs when the body does not receive enough protein and energy [calories] to maintain normal tissue structure and function. It can result from inadequate dietary intake, increased nutrient requirements, or conditions that impair nutrient absorption such as chronic illness), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and High Blood Pressure. Resident CR150's task for Amount Eaten (an areas in point of care where the nurse aides document the amount the resident ate at each meal) revealed that for the month of December 2025, there was no documentation to indicate the percent of meal he/she consumed for two of 13 opportunities. For the month of January 2026, there was no documentation to indicate the percent of meal he/she consumed for 23 of 93 opportunities. For the month of February 2026, there was no documentation to indicate the percent of meal he/she consumed for 12 of 84 opportunities. For the month of March 2026, there was no documentation to indicate the percent of meal he/she consumed for three of 27 opportunities. During an interview on 5/21/26, at 1:15 p.m. Nursing Home Administrator (NHA) confirmed that Resident CR150's clinical record for amount eaten lacked documentation for each meal as required. NHA further confirmed that staff should document the residents' meal intake after each meal. 28 Pa. Code 211.5(f)(v)(viii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services