STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395011	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platinum Ridge Ctr for Rehab & Healing	1050 Broadview Boulevard Brackenridge, PA 15014

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation and staff interview, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for one of three residents (Resident R9). Findings include: Review of the facility admission Agreement indicated the resident has a right to a dignified existence, self-determination, communication with and access to, persons and services inside and outside Center. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), anxiety, and depression. Review of the facility provided pressure ulcer list indicated Resident R9 developed a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to their right heel on 4/20/25. During an observation of wound care on 6/25/25, from 9:22 a.m. through 9:36 a.m., Registered Nurse (RN) Employee E2 wrote on the dressing after it was placed on Resident R9's right heel. During an interview on 6/25/25, at 9:37 a.m. RN Employee E2 confirmed the facility failed to maintain Resident R9's dignity when writing on the dressing after placement on the resident. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(a) Resident rights.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, and staff interview, it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medications for two of four residents (Residents R33 and R46). Findings include: Review of facility policy Psychotropic Medication Use dated 5/19/25, indicated residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-psychotics, anti-depressants, anti-anxiety medications, and hypnotics/sedatives. Review of facility policy Medication Regimen Reviews dated 5/19/25, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist provides the Director of Nursing (DON) and medical director with copy of all medication regimen reports. Upon receiving the MRR report from the pharmacist, the DON reviews the recommendations with the attending physician, responds to the report, and documents what (if any) actions were taken to address them. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/7/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic pain. Review of Resident R33's clinical record revealed an MRR completed by the consultant pharmacist on 3/31/25 that stated that order for Seroquel (an antipsychotic medication) written on 3/5/25, did not have an appropriate diagnosis for use of this medication and requested that physician address. Review of the above document for Resident R33 on 6/26/25, failed to reveal that the physician addressed and signed the MRR dated 3/31/25. During an interview on 6/26/25, at 2:11 p.m. the DON confirmed that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic medications for Resident R33. Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE]. Review of Resident R46's MDS dated [DATE], indicated diagnoses of anxiety, depression, and Bipolar Disorder (a mental condition marked by alternating periods of elation and depression). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 12/25/23, indicated to administer Diazepam (an anti-anxiety medication) 10 mg (milligrams) by mouth at bedtime for anxiety. Review of a physician order dated 12/25/23, indicated to administer Diazepam 10 mg by mouth in the afternoon for anxiety. Review of a physician order dated 12/27/23, indicated to administer Diazepam 5 mg by mouth one time a day for anxiety. Review of a physician order dated 12/25/23, indicated to administer Lorazepam (an anti-anxiety medication) 1 mg by mouth every two hours as needed for seizure. Review of a physician order dated 12/25/23, indicated to administer Sertraline (an anti-depressant medication) 50 mg by mouth in the morning for depression. Review of a physician order dated 6/4/24, indicated to administer Trazodone (an anti-depressant medication) 225 mg by mouth every 24 hours as needed for depression take at night. Review of Resident R46's clinical record failed to reveal documentation that a MRR had been completed by the consultant pharmacist for October and November 2024. During an interview on 6/26/25, at 10:45 a.m. the DON confirmed that the facility was unable to locate and provide documentation that medication regimen reviews were completed and that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic medications for Resident R46. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to individualize care plans to address the resident specific nutritional concerns for two of three residents (Resident R9, and R31), and failed to ensure direct care staff were aware of residents with fluid restriction orders to make certain acceptable parameters of nutritional status were maintained for one of two residents on physician ordered fluid restrictions (Resident R34). Findings include: The facility policy Medical Nutrition Therapy (MNT) Documentation dated 5/19/25, indicated the person centered care plan is based on the MNT assessment, the identified risk factors and nutritional needs, as well as individual preferences. Problems, risk factors, or concerns are described along with nutrition interventions and goals for improvement. Specific and measurable goals should be stated to maintain or achieve optimal nutritional status. Goals and approaches (interventions) should be individualized, person centered and should be coordinated with the interdisciplinary team. The resident has the right to refuse treatment and the care plan should reflect whether or not the individual is in acceptance of the care plan. Each time a re-assessment or progress note is completed, the care plan should be updated. The facility policy Fluid Restrictions and Sample Distribution of Fluids dated 5/19/25, indicated that fluid restrictions will be followed as per physician's orders. The amount of fluid allowed per 24-hour period will be specified in a written physician's order and sent to the food and nutrition service department in writing. The food and nutrition services department and the nursing department will determine how much fluid will be provided at meals and medication passes. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), osteoporosis (condition when the bones become brittle and fragile), and difficulty swallowing. Review of Resident R9's clinical record revealed the following physician's orders: · Ensure plus (a nutritionally dense drink) three times a day dated 10/15/21 · Magic Cup (a nutritionally dense ice cream) two times a day dated 11/15/22 · Pureed diet with mildly thick liquids and no straws dated 1/16/25 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R9's care plan last revised on 5/14/25, indicated that resident has had weight loss and interventions include the following: · Provide, serve diet as ordered · Provide and serve supplements as ordered. Review of Resident R9's care plan failed to include resident specific interventions for the physician ordered diet and supplements listed above. Review of the clinical record indicated Resident R31 was admitted to the facility on [DATE]. Review of Resident R31's MDS dated [DATE], indicated diagnoses of cancer, malnutrition, and depression. Section K0200 was marked that resident had loss of 5% or more in the last month or loss of 10% or more in 6 months, and is not on a physician-prescribed weight loss regimen. Section K0710 was marked that resident received 51% or more of total calories through tube feeding. Review of Resident 31's clinical record revealed the following physician's orders: · Enteral Feed (a nutritional feeding provided through a tube that is inserted into the gastrointestinal tract) Nutren 2.0 (a high calorie nutritional formula) 375 milliliter (ml) two times a day dated 5/21/25. · Enteral Feed Nutren 2.0 250 ml via tube at bedtime dated 5/21/25. · Pleasure tray diet (food for pleasure only- not intended for nutrition) full liquids (a diet composed of food and liquids that are liquid at room temperature) dated 5/22/25. Review of Resident R31's care plan last revised on 5/14/25, indicated interventions include the following: · Tube Feed as ordered During an interview on 6/26/25, at 10:18 a.m. Dietary Supervisor Employee E3 stated that Resident R31 has had weight loss on his tube feeding, but that resident will often pull out his feeding tube or refuse the tube feedings. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 31's nutritional care plan failed to include that resident has had weight loss, pulls out feeding tube, or refuses tube feedings. Care plan also failed to include resident specific interventions for the physician ordered tube feeding formula listed above. During an interview on 6/26/25, at approximately 2:28 p.m. the Dietary Supervisor Employee E3, and the Director of Nursing confirmed the facility failed to individualize care plans to address the resident specific nutritional concerns for Resident R9, and R31. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of high blood pressure, End Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood), and heart transplant status. Review of a physician order dated 3/23/25, indicated fluid restriction 1800 mL (milliliters) per 24 hours. The physician order did not indicate how much fluid was allotted to nursing and dietary. During an interview on 6/26/25, at 10:31 a.m. Dietary Supervisor Employee E3 stated, It should be broken down in the order for the fluid restriction. During this interview, Dietary Supervisor Employee E3 confirmed that the facility failed to ensure direct care staff were aware of residents with fluid restriction orders to make certain acceptable parameters of nutritional stats were maintained for Resident R34. 28 Pa. Code 201.18(b)(1)(Management. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of four residents (Residents R31). Findings include: Review of the clinical record indicated Resident R31 was admitted to the facility on [DATE]. Review of clinical record revealed that Resident R31 had a physician order for Enteral Feed Nutren 2.0 (a high calorie nutritional formula 375 milliliters (ml) twice a day and 250 ml daily dated 3/7/25, and discontinued on 4/1/25. Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/1/25, indicated diagnoses of cancer, malnutrition, and depression. Section K0520 indicated that resident received nutrition from a feeding tube while a resident. Review of clinical record indicated that Resident R31 was sent to the hospital on 4/1/25, and returned to the facility on 4/4/25. Review of Resident R31's clinical record revealed a nurses note dated 4/7/25, at 3:30 p.m. that Nutren was infusing without difficulty. Review of clinical record failed to reveal a physician order for Resident R31's enteral feeding from 4/4/25, through 4/7/25. During an interview on 6/16/25, at 2:25 p.m. the Director of Nursing confirmed the facility failed to obtain a physician's order for an enteral feeding from 4/4/25 through 4/7/25, and failed ensure that residents with an enteral feeding tube received appropriate treatment and services for Resident R31. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of two residents (Resident R30 and R38). Findings include: Review of facility policy Administering Medications through a small volume (handheld) Nebulizer (a device that converts liquid medication into an inhalable mist) dated 5/19/25, indicated to ensure that equipment is completely dry and store in a plastic bag when not in use. Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE]. Review of Resident R30's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/27/25, indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and asthma (condition where the airways narrow and swell). Review of a physician order dated 1/28/24, indicated to provide albuterol sulfate nebulization solution (a medication used for breathing difficulty) (2.5 milligrams/milliliter) 0.083% 3 milliliters inhale orally via nebulizer every six hours as needed for shortness of breath. During an observation on 6/23/25, at 10:20 a.m. Resident R30's nebulizer machine was observed on the bedside table with the mouthpiece on the bedside table, not stored in a bag while not in use. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and hypothyroidism (an underactive thyroid). Review of a physician's order dated 6/21/25, indicated to provide ipratropium- albuterol Inhalation solution (a medication used for breathing difficulty) 0.5-2.5 3 milligrams/3 milliliters 1 unit inhale orally every 4 hours as needed for wheezing until 6/28/25. During an observation on 6/23/25, at 10:07 a.m. Resident R38's nebulizer machine was observed on the bedside table with the mouthpiece on the bedside table, not stored in a bag while not in use. During an interview on 6/23/25, at 1:20 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R30 and R38's nebulizer mouthpiece was not stored in a bag while not in use, and confirmed that the facility failed to provide appropriate respiratory care for Resident R30 and R38. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (a machine that filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of three residents (Resident R34). Findings include: Review of facility policy Hemodialysis dated 5/19/25, indicated the facility will ensure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/30/25, indicated diagnoses of high blood pressure, End Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood), and heart transplant status. Review of a physician order dated 3/14/25, indicated the resident receives hemodialysis at an outside facility every Monday, Wednesday, and Friday. Review of a physician order dated 3/24/25, indicated the dialysis communication form must be sent with resident to dialysis and reviewed upon return every Monday, Wednesday, and Friday. Review of Resident R34's clinical record did not include complete communication forms for eight days during the period of 6/1/25, through 6/24/25. The incomplete forms were on the following dates: 6/2/25, 6/4/25, 6/6/25, 6/9/25, 6/13/25, 6/16/25, 6/18/25, and 6/23/25. During an interview on 6/24/25, at 9:43 a.m. Licensed Practical Nurse Employee E1 confirmed the above dates did not include complete dialysis communication forms. During an interview on 6/24/25, at 1:25 p.m. the Director of Nursing confirmed that the facility failed to provide consistent and complete communication with the dialysis center for Resident R34. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure a resident received appropriate behavioral health services to maintain the highest practicable well-being for one of two sampled residents (Resident R58). Findings include: The facility Trauma informed care and culturally competent care policy last reviewed 5/19/25, indicated that trauma-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Traumatic events which may affect residents during their lifetime include: physical, sexual and emotional abuse, neglect, and interpersonal or community violence. Developing individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. Examples include food choices, clothing preferences, and physical contact or provision of care by a person of the opposite sex. Review of Resident R58's admission record indicated she was originally admitted on [DATE]. Review of Resident R58's hospital record dated 2/12/24, indicated she was being assessed at the hospital for a possible sexual assault. Review of Resident R58's MDS assessment (Minimum Data Set: MDS - a periodic assessment of care needs) dated 2/12/25, indicated she had diagnoses that included aphasia, vascular dementia (a persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), hyperlipidemia (elevated lipid levels within the blood), and epilepsy (a long-term disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells). Review of Resident R58's trauma assessment dated [DATE], indicated that she was assessed for traumatic triggers and scored 0 for all questions and severity. Review of Resident R58's care plans dated 5/22/25, indicated she had a history of sexual abuse and she will have minimal signs or symptoms of traumatic symptoms. Further review of Resident R58's care plan did not indicate behavioral health assistance (consider gender of staff providing Resident R58 care) related to the Resident R58 sexual abuse history. During an interview on 6/26/25, at 10:41 a.m. information disseminated to the Nursing Home Administrator (NHA) that the failed to ensure a Resident R58 received appropriate behavioral health services to maintain the highest practicable well-being as required. 28 Pa. Code 201.14(a) Responsibility of licensee (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(3) Nursing services 28 Pa. Code 211.16(a) Social services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and failed to ensure that any irregularities submitted in the MRR by pharmacy were acted upon timely for three of five residents (Residents R29, R33, and R46). Findings include: Review of facility policy Medication Regimen Reviews dated 5/19/25, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist provides the Director of Nursing (DON) and medical director with copy of all medication regimen reports. Upon receiving the MRR report from the pharmacist, the DON reviews the recommendations with the attending physician, responds to the report, and documents what (if any) actions were taken to address them. Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE]. Review of Resident R29's MDS (minimum data set a periodic assessment of resident needs) dated 5/8/25, indicated diagnosis of Alzheimer disease (type of dementia that affects the memory, thinking and behavior) hypertension (pressure in your blood vessels is to high) and diabetes mellitus (when your blood sugar is too high). Review of Resident R29 clinical record indicated two MMR (monthly medication reviews) completed by the pharmacist - one in 3/10/25 and 4/28/25. The 4/28/25, review failed to include any recommendations or documentation showing that the pharmacy reviewed the medications, it reiterated a list of Resident R29 medications only. During an interview on 6/26/25, at 11:21 a.m. Director of Nursing (DON) confirmed that the facility failed to complete monthly medication reviews. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and chronic pain. Review of Resident R33's clinical record revealed an MRR completed by the consultant pharmacist on 3/31/25, that stated that order for Seroquel (an antipsychotic medication) written on 3/5/25, did not have an appropriate diagnosis for use of this medication and requested that physician address. Review of the above document for Resident R33 on 6/26/25, failed to reveal that the physician addressed and signed the MRR dated 3/31/25. During an interview on 6/26/25, at 2:11 p.m. the Director of Nursing confirmed that the facility failed to ensure that the irregularities submitted in the MRR by pharmacy were acted upon timely for resident R33. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395011	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platinum Ridge Ctr for Rehab & Healing	1050 Broadview Boulevard Brackenridge, PA 15014

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE]. Review of Resident R46's MDS dated [DATE], indicated diagnoses of anxiety, depression, and Bipolar Disorder (a mental condition marked by alternating periods of elation and depression). Review of Resident R46's clinical record failed to reveal documentation that a MRR had been completed by the consultant pharmacist for October and November 2024. During an interview on 6/26/25, at 10:45 a.m. the DON confirmed that the facility failed to provide documentation that a medication regimen review was completed for Resident R46 in October and November 2024. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy, observations and staff interview, it was determined that the facility failed to properly label and date food products, in the Main Kitchen. (Main Kitchen). Findings include: Review of facility policy Food Receiving and Storage, dated 5/19/25, indicated that all foods stored in the refrigerator or freezer are covered, labeled, and dated. During an observation in the Main Kitchen on 6/23/25, at 9:30 a.m. the following was noted: · A bag of frozen vegetables in the walk-in freezer with no receive date labeled. · An opened bag of chopped onions in the reach-in refrigerator with no label or date. · Four bags of gelatin mix in the dry storage room with no receive date labeled. During an interview on 6/23/25, at 9:5 am the Dietary Supervisor Employee E3 confirmed that the facility failed to properly label and date food products in the Main Kitchen. Pa Code 201.14(a) Responsibility of licensee. Pa Code 201.18(b)(3) Management.