

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Eden Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Broadview Boulevard Brackenridge, PA 15014	
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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the new development of a pressure ulcer. This resulted in actual harm of the development of a facility-acquired Stage 3 (full thickness skin loss that extends into the subcutaneous fat) pressure ulcer for one of three residents (Resident R1). Findings include: Review of facility policy Prevention of Pressure Injuries dated 6/18/26, indicated the purpose of this procedure is to provide an overview of current standards of practice for pressure injury prevention. Interventions are individualized according to each resident's risk factors for pressure injury, clinical condition, and resident wishes and goals of care. General Guidelines include: assess the resident upon arrival to the facility for pressure injury risk factors, and use a standardized pressure injury screening tool to determine and document risk factors. Prevention include: keep the skin dry and hydrated, clean promptly after episodes of incontinence, avoid alkaline soaps and cleansers, use a barrier product to protect skin from moisture, use incontinence products with high absorbency, do not rub or otherwise cause friction on skin, use facility-approved protective dressings for at risk individualizes. Mobility/Repositioning: implement an early mobilization program based on activity tolerance, reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. For example, repositioning every 2-3 hours when an appropriate pressure redistribution surface is used. Review of facility policy Braden Scale - Pressure Injury Risk assessment dated [DATE], indicated a Braden Scale (a standardized assessment tool used in healthcare to evaluate a patient's risk of developing pressure injuries) risk assessment shall be completed by a licensed nurse for every resident according to the schedule below. Results shall be documented in the resident's medical record, and residents identified as at risk (Braden score of 18 or below) shall have appropriate preventative interventions initiated and incorporated into the plan of care. The Braden Scale shall be completed on admission, weekly x 4, quarterly, with significant change, and upon return from hospital. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's admission Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/28/26, indicated diagnoses of anemia (low healthy red blood cells), and hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infraction (a stroke) affecting left non-dominant side, and muscle weakness. Section GG: Functional Abilities indicated Resident R1 required dependent assistance (Helper does all of the effort, resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to roll left and right, to move from a sitting to a lying position, to move to a sitting to a standing position, and to transfer between a chair and the bed. Section M - Skin Conditions, Question M0150 indicated the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395011	Facility ID: 395011 If continuation sheet Page 1 of 24

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	bed/offload with pillows if boots are not available. Pressure redistribution mattress per facility protocol - air mattress in place and functioning, check q shift. Wheelchair pressure redistribution cushion per facility protocol - WC cushion present; does get OOB (out of bed). Nutrition recommendations: patient/staff educated on protein intake in relation to promoting wound healing. Additional recommendations: incontinence care per staff. Fall safety prevention per staff. May continue house stock barrier cream every shift and PRN as prophylactic measure. Plan of care documentation and plan of care has been made available to facility staff and medical team via EMR. Plan of care and education discussed with facility staff. Review of Resident R1's clinical record failed to include documentation that preventative measures were implemented as ordered, such as: pressure relief/offloading side to side offloading while in bed and house stock barrier cream every shift and PRN, as had been stated in the 7/1/26, Skin/Wound progress note. During an interview on 7/21/26, at 1:30 p.m. LPN Employee E3 stated, Stock barrier cream goes on the MAR (medication administration record) or TAR (treatment administration record), it is something for the nurses to sign off. During an interview on 7/22/26, at 8:37 a.m. Nurse Aide (NA) Employee E5 stated, Pressure ulcer preventative measures, like barrier creams repositioning, are communicated to us by the nurse and it is in the POC (plan of care) to document. It is also listed on the Kardex (a snapshot of resident care needs). During an interview on 7/22/26, at 8:42 a.m. LPN Employee E1 stated, I look on the orders to see preventative measures for pressure ulcers. Barrier cream is to be documented against by the nurse in the MAR/TAR. During an interview on 7/22/26, at 9:53 a.m. Wound Service CRNP Employee E4 stated, I communicate recommendations to the facility during weekly wound rounds with the wound care nurse. Treatment orders are communicated on the custom wound report that I provide to the facility every week. Wound Care Nurse Employee E6 is who implements the orders. Wound Care Nurse Employee E6 will enter all orders, treatment changes, imaging, diagnostics, medications, consults for therapy. This has always been the process. I send the custom wound report the same day as wound rounds, I send it before I leave the building. During an interview on 7/22/26, at 9:58 a.m. Infection Preventionist Employee E7 stated, Preventative pressure ulcer measures gets communicated to the nurse aides by putting it on the plan of care tasks to be documented against. All residents are placed on pressure redistribution mattresses unless a more specialty mattress is indicated. During an interview on 7/22/26, at 11:44 a.m. Wound Care Nurse Employee E6 stated, Wound Service CRNP Employee E4 and I talk during wound rounds, she will document her recommendations on the custom wound report and that gets sent to me, Infection Preventionist Employee E7, and the Director of Nursing (DON). I am responsible for updating orders, cleaning up old orders, notifying resident/resident representatives of changes, and updating the doctor. I review order changes and interventions with the nurses and nurse aides on the floor. House barrier cream is put in as an order for nurses to sign off. It should be under the treatments. Compound creams would be under the MAR. House barrier cream is the standard to order for preventative measures. Air mattresses are considered when someone has skin breakdown. Review of Resident R1's care plan initiated on 4/27/26, indicated that resident has actual impaired skin integrity related to CVA (stroke) with left side hemi and neglect, need for assistance with ADLs (activities of daily living), incontinent of B&B. Interventions included administer medications and treatments as ordered. Observe for ineffectiveness and side-effects, report abnormal findings to the provider. Complete wound evaluation to monitor the progress of the resident's skin condition. Dietitian as needed. Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration (softening and breakdown of skin around a wound due to prolonged moisture) to provider. Obtain labs and diagnostics as ordered and report abnormal findings to the provider. Provide diet and supplements as ordered, see (continued on next page)		

Department of Health & Human Services
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NAME OF PROVIDER OR SUPPLIER Eden Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Broadview Boulevard Brackenridge, PA 15014	
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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nutrition POC. Wound consult PRN. The care plan was revised on 5/7/26, with interventions including low air-loss mattress, check function and settings q (every) shift. Resident R1's comprehensive care plan indicated interventions of house stock barrier cream every shift and prn and side-to-side offloading while in bed were not implemented until 7/8/26. Review of Resident R1's physician orders from 4/21/26, through 7/8/26, failed to include an order to apply barrier cream every shift and as needed as prophylactic measure and failed to include an order to perform side to side offloading while in bed, per Wound Service CRNP Employee E4's recommendations. Review of Resident R1's clinical record failed to include documentation that it was communicated to the nurse aides to apply barrier cream every shift and as needed as a prophylactic measure and failed to include documentation that side to side offloading was performed, per Wound Service CRNP Employee E4's recommendations. The facility failed to provide additional documentation that the facility performed an assessment of Resident R1's wound between weekly rounds with Wound Service CRNP Employee E4. During an interview on 7/23/26, at 9:58 a.m. the DON confirmed that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the new development of a pressure ulcer. This resulted in actual harm of the development of a Stage 3 facility-acquired pressure ulcer for Resident R1. 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)(3)(5) Nursing services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions creating the potential for cross contamination in the main kitchen of the facility. Findings include: During an observation with Food Service Director Employee E9 in the main kitchen on 7/20/26, at 9:15 a.m., revealed the ice machine had a build up grime, and dark colored debris inside the ice machine. During an observation with Food Service Director Employee E9 in the main kitchen on 7/20/26, at 10 a.m. revealed Dietary Employee E16 wearing beard guard under chin. During an interview on 7/20/26, at 10:15 a.m., Dietary Manager Employee E9 confirmed that the facility failed to maintain sanitary conditions and practice proper infection control techniques to prevent cross contamination in the main kitchen.28 Pa. Code: 201.14(a) Responsibility of licensee.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 facility policy, clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the resident's attending physician monthly for three of seven residents (Resident R4, R11, and R26). Findings include: Review of the facility policy Medication Regimen Reviews dated 6/18/26, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly. Review of the admission record indicated Resident R4 was admitted to the facility 10/8/25. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/8/26, indicated diagnoses of dementia (decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities), diabetes mellitus and major depressive disorder. Review of Resident R4's MRR's on the following dates were signed by a Certified Registered Nurse Practitioner (CRNP) and not by the physician as required: 3/6/26- MRR signed by CRNP Review of the admission record indicated Resident R11 was admitted to the facility 8/28/25. Review of Resident R11's MDS dated [DATE], indicated diagnoses of depression, schizophrenia (characterized by thoughts or experiences that seem out of touch with reality, disorganized speech or behaviors, and decreased participation in activities of daily living), and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Review of Resident R11's MRR dated 2/25/26, was signed by a Certified Registered Nurse Practitioner (CRNP) and not by the physician as required. Interview on 7/24/26, at 9:08 a.m. Infection Preventionist Employee E7 confirmed a CRNP signed Resident R11's MRR dated 2/25/26, and not by the physician as required. Review of the admission record indicated Resident R26 was admitted to the facility 12/17/25. Review of Resident R26's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/19/26, indicated diagnoses of dementia (decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities), protein-calorie malnutrition and hyperlipidemia. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident R26's MRR's on the following dates were signed by a Certified Registered Nurse Practitioner (CRNP) and not by the physician as required: 5/5/26-MRR signed by CRNP Interview on 7/24/26, at 8:45 a.m. the Infection Preventionist Employee E7 confirmed that a CRNP signed Residents R4, R26 MRR's on the dates noted instead of the physician as required. 28 Pa Code: 201.14(a) Responsibility of licensee28 Pa Code 211.12(d)(1)(3)(5) Nursing services		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **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 accommodate the call bell needs for two of five residents (Residents R67 and R85). Findings include: Review of facility policy Call System, Residents dated 6/18/26, indicated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/30/26, indicated diagnoses of high blood pressure, arthritis (inflammation of one or more joints, causing pain and stiffness), and muscle weakness. During an observation on 7/20/26, at 10:29 a.m. Resident R67 was observed lying in bed. Resident R67's call bell was clipped to the privacy curtain to the right of the resident, out of the resident's reach. During this observation, Resident R67 stated, How the hell am I supposed to reach that? During an interview on 7/20/26, at 10:49 a.m. Nurse Aide employee E2 confirmed Resident R67's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R67's call bell needs. Review of the clinical record indicated Resident R85 was admitted to the facility on [DATE]. Review of Resident R85's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 7/20/26, at 9:17 a.m. Resident R85 was observed lying in bed. Resident R85's call bell was wrapped around the left side rail, however the cord for the call bell was unplugged from the wall panel and could not be activated. During an interview on 7/20/26, at 9:27 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R85's call bell cord was unplugged from the wall panel. LPN Employee E1 plugged the cord back in to the wall panel and verified that the call bell could be activated. The call bell light outside of the resident room was observed on and audible dinging could be heard at the nurse's station. During an interview on 7/20/26, at 9:27 a.m. LPN Employee E1 confirmed Resident R85's call bell was not accessible and that the facility failed to accommodate Resident R85's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident records, resident business office documents and staff interview, it was determined that the facility failed to ensure that a resident right to manage their financial affairs was upheld by obtaining a signed authorization for one of three sampled resident records (Resident R37). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aids in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment. Review of Resident R37's admission to the facility on [DATE]. Review of Resident R37's admission signed documents dated 11/24/25, indicated a family member signed Resident R37 into the facility. Review of Resident R37's power of attorney (POA) financial document dated 2/10/26, indicated he signed over POA authorization to a relative. Review of Resident R37's MDS assessment (Minimum Data Set assessment: MDS - a periodic assessment of resident care needs) dated 3/30/26, indicated that he had diagnoses that included depressive disorder (a state of consistent sadness and loss of interest interfering in daily life activities), lymphedema (a blockage in the lymphatic system causing swelling to legs or arms), gout (a form of arthritis involving severe pain), and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). Section C-0500 BIMS Summary Score indicated the Resident R37 scored a 11, moderately impaired. Review of Resident R37's care plan dated 3/30/26, indicated to actively involve the resident and resident's family in the plan of care. Review of Resident R37's resident fund authorization form (a form to open a resident fund account) indicated Resident R37's fund account was provided with a fax date of 4/16/26, and no signature date. The form was found signed by Resident R37. The section stating Anyone signing for the resident was left blank and without any additional information. Further review did not indicate that Resident R37's POA was involved in opening the fund account. Review of the facility trial balance (a balance showing current residents with a trust fund with the facility) dated 7/20/26, indicated Resident R37 account was still active. During an interview on 7/23/26, at 11:59 a.m. Licensed Practical nurse (LPN)/Business office staff Employee E15 was asked about Resident R37's fund authorization and signature and stated: I'm not sure who signed that. When Licensed Practical nurse (LPN)/Business office staff Employee E15 was asked about when Resident R37 fund account was opened she stated: i was able to get the start date and it shows open 4/16/26. During an interview on 7/23/26, at 2:28 p.m. information was disseminated to the Nursing Home Administrator (NHA) and Director of Nursing (DON) that the facility failed to ensure that Resident R37's right to manage his financial affairs was upheld by obtaining a signed authorization for a resident fund account as required. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident rights.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, resident and staff interviews it was determined that the facility failed to provide a safe, clean, comfortable and homelike environment for one of five resident wheelchairs (Resident R5) and failed to have bath linens in good condition for one of three bath linen items (washcloths). Findings include: Review of the facility policy Homelike Environment dated 6/18/26, indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; b. comfortable (minimum glare) yet adequate (suitable to the task) lighting; c. inviting colors and decor; d. personalized furniture and room arrangements; e. clean bed and bath linens that are in good condition; f. pleasant, neutral scents; g. plants and flowers, where appropriate; h. comfortable and safe temperatures (71 F - 81 F); [NAME]. comfortable sound levels. Observation on 7/20/26, at 12:11 p.m., Resident R5 was sitting in a wheelchair socializing with others. The chair's frame, seat, and wheels were corroded with grime, debris, and long hairs. Interview and observation on 7/20/26, Nurse Aide (NA) Employee E10 confirmed Resident R5's chair's frame, seat, and wheels were corroded with grime, debris, and long hairs. Review of an anonymous complaint filed with the state on 7/10/26, indicated residents do not have access to linens. Review of a Resident Council meeting held on 7/21/26, at 1:24 p.m. indicated that two of six residents stated washcloths are not well kept and residents could see right through the fabric. Observation of the facility linen storage area on 7/22/26, at 1:51 p.m. washcloths were found to be available; however, upon opening a brand-new package of washcloths, they were noted to be very thin and could see through the fabric. Interview and observation on 7/22/26, at 1:54 p.m. the Nursing Home Administrator confirmed the washcloths were very thin and could see through the fabric. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b) Management		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to assess the functional status of the individual resident to determine if the use of a bolster (a long, thick cushion) is a restraint for one of two residents (Residents R1). Findings include: Review of facility policy Use of Restraints dated 6/18/26, indicated physical restraints are defined as any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's admission Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/28/26, indicated diagnoses of anemia (low healthy red blood cells), and hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infraction (a stroke) affecting left non-dominant side, and muscle weakness. During an observation on 7/20/26, at 9:08 a.m. Resident R1 was observed lying in bed and the mattress had bilateral (on both sides) raised edges on the top and bottom portions. Review of Resident R1's clinical record failed to include a physician order for bolsters or a plan of care related to the use of bolsters. Further review of Resident R1's clinical record failed to identify any assessments or ongoing evaluations for the usage of bolsters on the resident's mattress. During an interview on 7/23/26, at 11:43 a.m. Infection Preventionist Employee E7 confirmed that the facility failed to assess the functional status of the individual resident to determine if the use of a bolster (a long, thick cushion) is a restraint for one of two residents (Residents R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two of six residents (Residents R1 and R4).Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's admission Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/28/26, indicated diagnoses of anemia (low healthy red blood cells), and hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infraction (a stroke) affecting left non-dominant side, and muscle weakness. Review of the clinical record indicated Resident R1 was transferred to the hospital on 6/22/26, and returned to the facility on 6/30/26. Review of Resident R1's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 6/22/26. During an interview on 7/23/26, at 12:13 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for Resident R1. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of dementia (decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities), diabetes mellitus and major depressive disorder. Review of the clinical record indicated Resident R4 was transferred to the hospital on 4/21/26, and returned to the facility on 4/24/26. Review of Resident R4's clinical record, the facility failed to include documented evidence that the facility provided a written notification to the Office of Long-Term Care Ombudsman for the hospitalization on 4/21/26. During an interview on 7/23/26, at 1:56 p.m. the NHA confirmed that the facility failed to provide written transfer notice to a representative of the Office of Long-Term Care Ombudsman for one of six residents as required (Resident R4). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to provide written summary of the baseline care plan to the resident and/or representative for two of six residents reviewed (Resident R78 and R94). Findings include: Review of the facility policy Care Plan-Baseline last reviewed 6/18/26, indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: Initial goals based on admission orders and discussion with the resident/representative. Physician orders Dietary orders Therapy services Social service The baseline care plan is used until the staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission. Review of the clinical record indicated Resident R94 admitted to the facility on [DATE]. Review of the Resident R94s Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/3/26, indicated the diagnoses of fracture of first lumbar vertebra, morbid obesity and cirrhosis of liver. Resident R94's clinical record lacked evidence that a written summary of the baseline care plan was reviewed on 6/12/26, 14 days after admission. Review of the clinical record indicated Resident R78 admitted to the facility on [DATE]. Review of the Resident R78's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/9/26, indicated the diagnoses of urinary tract infection, diabetes mellitus and ataxic gait (neurological condition characterized by poor muscle control). Resident R78's clinical record lacked evidence that a written summary of the baseline care plan was provided to Resident R78 and/or his/her representative. During an interview completed on 7/23/26, at 12:35 p.m. the Nursing Home Administrator (NHA) confirmed there were no evidence that a written summary of the baseline care plan was provided to Resident R78 and/or their representatives and Resident R94 within the required timeframe. 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of three residents (Residents R64). Findings include: Review of the facility policy Splint and Assistive Device Policy dated 6/18/26, indicated every splint comes with a wearing schedule and skin-check instructions. Standard cleaning of fabrics with laundry. Nursing: Apply/remove per schedule, check skin, report concerns. Review of the admission record indicated Resident R64 admitted to the facility on [DATE]. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/7/26, indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and high blood pressure. Review of Resident R64's current physician orders indicated resident to wear left resting hand splint on with morning care, off with evening care. Gentle stretch to left hand, fingers, and wrist prior to donning (putting on) the splint. Staff to check skin before and after application. Alert therapy of any skin issues or changes. Review of Resident R64's current care plan indicated resident has a functional ability deficit and requires assistance with self-care and mobility related to weakness. Wear left resting hand splint on with morning care, off with evening care. Gentle stretch to left hand, fingers, and wrist prior to donning the splint. Staff to check skin before and after application. Alert therapy of any skin issues or changes. Observation on 7/20/26, at 9:00 a.m. Resident R64 was observed resting in bed with her arms on top of the covers. The resident did not have a splint on her left hand as ordered. Observation on 7/20/26, at 12:00 p.m. Resident R64 was observed resting in bed with her arms on top of the covers. The resident did not have a splint on her left hand as ordered. Interview and observation on 7/20/26, at 12:03 p.m. Therapy Employee E12 entered Resident R64's room and indicated the splint was not on, but she was putting it on the resident now. Observation on 7/21/26, at 11:00 a.m. Resident R64 was observed resting in bed with her arms on top of the covers. The resident did have a splint on her left hand as ordered, that was covered in a light tan dried debris on the fabric. Interview on 7/21/26, at 11:05 a.m. the Nursing Home Administrator was informed the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of three residents (Residents R64). 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)(3)(5) Nursing services.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (G- Tube, a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of four residents (Resident R64). Findings include: Review of facility policy Enteral Nutrition (liquid food and medicine directly into the stomach or small intestine) dated 6/18/26, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. Review of the admission record indicated Resident R64 admitted to the facility on [DATE]. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/7/26, indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and high blood pressure. Review of Resident R64's current physician orders indicated Glucerna 1.5 (liquid nutrition) at 87 ml/hr (milliliters/hour) via pump, via G tube. Start at 9:00 a.m. and stop at 9:00 p.m. to provide total volume of 1,044mls over a 12-hour period. Review of Resident R64's current care plan indicated to administer enteral nutrition per physician orders. Observation on 7/20/26, at 10:48 a.m. Resident R64 was resting in bed connected to the enteral nutrition pump. The pump's screen displayed an error message, and the pump was not infusing per order. The feeding bag was labeled as being hung at 9:00 a.m. Interview on 7/20/26, at 10:49 a.m. Licensed Practical Nurse (LPN) Employee E11 confirmed the pump was not running and she was not aware. Observation on 7/21/26, at 1:29 p.m. Resident R64 was resting in bed connected to the enteral nutrition pump. The pump's screen displayed a hold error message. Interview on 7/21/26, at 1:33 p.m. LPN Employee E13 was informed Resident R64's pump was not running. LPN Employee E13 indicated she was not aware the pump was on hold and she did not turn if to hold. Indicated that the Nurse Aides (NA's) must have put it on hold to do care and didn't turn it back on. 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 Note: The nursing home is disputing this citation.	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 five residents (Residents R64 and R85). Findings include: Review of the facility policy Oxygen Administration dated 6/18/26, indicated oxygen therapy is administered by way of an oxygen mask or nasal cannula. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Review the physician's order for oxygen administration. Review of the facility policy CPAP/BiPAP Support (continuous positive airway pressure/bilevel positive airway pressure) indicated BiPAP delivers CPAP but allows separate pressure settings for expiration (EPAP) and inspiration (IPAP). Review the resident's medical record to determine their baseline and physician orders. Review of facility policy Nebulizer Tubing Storage and Replacement Policy dated 6/18/26, indicated nebulizer (a machine used to deliver aerosolized medications) tubing, medication cups, and mouthpieces/masks shall be cleaned, dried, stored, and replaced according to manufacturer recommendations and facility infection prevention practices. After each treatment, clean the medication cup and mask/mouthpiece according to facility protocol and manufacturer instructions. Once completely dry, store the medication cup and mask/mouthpiece in a clean, dry, covered container or resealable plastic bag designated for that resident. Review of the admission record indicated Resident R64 admitted to the facility on [DATE]. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/7/26, indicated diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and high blood pressure. Review of Resident R64's current physician orders indicated BiPAP every night at bedtime and as needed. BiPAP setting: Inspiratory Pressure: 15. Expiratory Pressure: 6. Oxygen: 5 Liters at bedtime. Oxygen at 5 lpm (liters per minute) per nasal cannula related to respiratory failure every shift. Review of Resident R64's current care plan failed to include care and management of the BiPAP machine as required. Observation on 7/21/26, at 10:31 a.m. Resident R64 was observed resting in bed. Resident failed to have a nasal cannula in their nose or a BiPAP mask on. Resident was breathing on room air only. Interview on 7/21/26, at 10:32 a.m. when Resident R64 was asked why she wasn't wearing her oxygen, she indicated staff took it off and did not put it back on. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and observation on 7/21/26, at 10:33 a.m. Licensed Practical Nurse (LPN) Employee E13 confirmed the oxygen was not in place as ordered. Interview on 7/21/26, at 10:45 a.m. Infection Preventionist Employee E7 confirmed Resident R64's plan of care failed to include care and management of the BiPAP. Review of the clinical record indicated Resident R85 was admitted to the facility on [DATE]. Review of Resident R85's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).Review of a physician order dated 1/5/26, indicated to administer Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (milligram/milliliter) 3 mL inhale orally every 6 hours as needed for SOB (shortness of breath)/wheezing.During an observation on 7/20/26, at 9:27 a.m. Resident R85's nebulizer machine was observed on the resident's bedside table. No date was observed on the tubing, and the mouthpiece was stored on top of the machine, not in a bag while not in use. During an interview on 7/20/26, at 9:27 a.m. LPN Employee E1 confirmed the above observations and that the facility failed to provide appropriate respiratory care for Resident R85. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization and failed to develop and implement an individualized person-centered care plan for a resident who was at risk for re-traumatization for one of two residents (Resident R30). Findings include: Review of facility policy Trauma Informed Care and Culturally Competent Care dated 6/18/26, indicated 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. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. 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 4/17/26, indicated diagnoses of high blood pressure, depression, and anemia (low levels of healthy red blood cells in the blood). Review of a psychiatry progress note dated 5/13/26, stated, Patient is alert up to W/C (wheelchair) sitting quietly in his room having lunch. Cooperative with the interview. He would become tearful at times describing sx (symptoms) of depression and PTSD (Post Traumatic Stress Disorder - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Says, I don't know if the medicine is strong enough. PTSD Based Symptoms: Assessed and endorsed symptoms that include: avoidance of trauma reminder, flashbacks, re-experiencing, and dissociation. Review of Resident R30's comprehensive care plan did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder and failed to identify any triggers and how to avoid them. During an interview on 7/23/26/26, at 1:59 p.m. Social Worker Employee E8 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization and failed to develop and implement an individualized person-centered care plan for a resident who was at risk for re-traumatization for Resident R30. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.		

Department of Health & Human Services
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observations, and staff interviews, it was determined that the facility failed to store medications and biologicals in a safe, secure, and orderly manner for one of three medication rooms (3 South Medication Room). Findings include: Observation on [DATE], at 8:59 a.m. of the 3 South Medication Room revealed the following expired items:-Eight culture swabs expired on [DATE].-Nine culture swabs expired on [DATE].-Ten culture swabs expired on [DATE].-Tuberculin vial labeled opened on [DATE]. Interview on [DATE], at 9:03 a.m. Licensed Practical Nurse (LPN) Employee E14 confirmed the above items were expired as noted. 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined the facility failed to obtain laboratory services as ordered for one of five residents reviewed (Closed Resident Record CR99). Findings include: Review of the clinical record indicated Closed Resident Record CR99 was admitted to the facility on [DATE]. Review of Closed Resident Record CR99's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/13/26, indicated diagnoses of high blood pressure, anxiety, and muscle weakness. Review of a physician order dated 6/17/26, indicated to obtain a CBC (Completed Blood Count - a test that measures red blood cell, hemoglobin, white blood cell, and platelet levels in the blood) and BMP (Basic Metabolic Panel - a common blood test that measures eight different substances in the blood, including electrolytes and glucose) one time only for monitoring on 6/22/26. Review of Closed Resident Record CR99's clinical record failed to reveal documentation that the CBC was obtained and completed as ordered by the physician on 6/22/26. During an interview on 7/23/26, at 1:11 p.m. Infection Preventionist Employee E7 confirmed that the facility failed to obtain laboratory services as ordered for Closed Resident Record CR99. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		