STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Rehab and Health	246 Friendship Circle Beaver, PA 15009

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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 review of facility policy, observations and staff interview, it was determined that the facility failed to properly store, label and date food items, and failed to properly perform handwashing in the Main kitchen, and also failed to maintain sanitary conditions on the second floor kitchenette which created the potential for cross contamination in one of six kitchenettes (second floor). Findings include: Review of the facility policy Food Storage dated 10/1/25, indicated that un-served leftovers shall be labeled, dated, and stored for a period not to exceed seven days. Review of the facility policy Personnel Standards dated 10/1/25, indicated that hands must be washed after each trip to the restroom, after leaving storage rooms, dumpster areas, washrooms, after touching hair, mouth, or nose, and at any other time it is necessary. During an observation, and interview on 3/9/26, at 9:45 a.m. the Dietary Manager (DM) Employee E19 confirmed that in walk-in refrigerator Number One of the Main Kitchen an opened package of sliced turkey was noted to be unsealed, with no label or date During an observation on 3/10/26, at 1:21 p.m. in the Dish Room, Dietary Aide Employee E20 was observed loading dirty dishes into the dish machine, and then remove clean dishes from the dish machine without washing her hands. During an interview on 3/10/26, at 1:21 p.m. DM Employee E20 confirmed that the facility failed to properly perform handwashing which created the potential for foodborne illness. During an observation 3/10/26 at 10:00 a.m. of the second floor kitchenette the following was observed: -Ice machine, scoop stored in machine, no separate scoop holder -mayonnaise, no label or date - (2) nonfat peach yogurts, no label or date - starbucks creamer, no label or date - pizza, individual, no laebl or date - frozen hot wings, no label or date - (2) crispy rice cereal, no label or date During an interview on 3/10/26 at 10:30 a.m., Registered Nurse Employee E18 confirmed that the facility failed to maintain sanitary conditions which created the potential for cross contamination in one of six unit kitchenette. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.28 Pa. Code: 201.14(a) Responsibility of licensee.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of seven residents sampled with facility-initiated transfers (Residents R9, R55, R79, R178), failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of seven resident hospital transfers (Resident R9), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for seven of seven resident hospital transfers (Resident R9, R10, R55, R79, R178, R273, R300).Findings include: Review of facility policy Emergency Transfer and Discharge reviewed 10/1/25, indicated the facility shall make an emergency transfer or discharge when it is in the best interest of the resident. When a resident is transferred, a copy of the clinical summary shall be sent to the facility that will continue the care of the resident. Information that must be communicated to the receiving provider must include a minimum of the following: contact information of facility provider, contact information for the resident's representative, advanced directive information, special instructions or precautions for ongoing care, comprehensive care plan, and a copy of discharge summary. Information sent must be documented in the medical record. Discharge information will be reported to the state ombudsman via email. Review bed hold policy with residents or their representative and provide a copy. Resident R9's clinical record revealed an admission date of 11/18/25, with diagnoses including open wound of the scrotum and testes, muscular dystrophy (group of genetic diseases that cause progressive muscle weakness and degeneration), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), and neuromuscular dysfunction of the bladder (injury or disease interrupts the electrical signals between your nervous system and bladder function). Departmental progress notes dated 10/14/25, and 12/04/25, indicated that Resident R9 was transferred to the acute care hospital, lacked evidence that the facility had communicated specific information to the receiving health care provider for the resident's transfer and expected to return, which included the resident's care plan goals, advanced directive instructions for ongoing care, resident representative information and, all information necessary to meet the resident's specific needs at the receiving facility. Further review of Resident R9's clinical record lacked evidence that the facility's bed hold policy was made available to the resident and/or the resident's representative at the time of the transfer, and documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 12/20/25. During an interview on 3/11/26, at 10:25 a.m. the Director of Nursing confirmed there was no evidence of the bed hold policy and evidence that the facility communicated specific information to the receiving health care provider at the time of transfer on 10/14/25, and 12/04/25. Resident R10's clinical record revealed an admission date of 8/04/25, with diagnoses including Human Immunodeficiency Virus Disease (HIV- virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases), extradural and subdural abscess (bacterial infection in the brain and/or spinal cord), and paraplegia. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Departmental progress notes dated 1/19/26, indicated that Resident R10 was transferred to the acute care hospital for evaluation and treatment. Review of Resident R10'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 1/19/26. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/26, indicated diagnoses of high blood pressure, depression, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of the clinical record indicated Resident R55 was transferred to the hospital on 3/2/26, and returned to the facility on 3/3/26. Review of Resident R55's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record revealed Resident R79 was admitted to the facility on [DATE]. Review of Resident R79'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 anxiety. Review of the clinical record indicated Resident R79 was transferred to the hospital on [DATE], and returned to the facility on [DATE]. Review of Resident R79's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals. Review of Resident R79'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 12/16/25. Review of the clinical record revealed Resident R178 was admitted to the facility on [DATE]. Review of Resident R178's MDS dated [DATE], indicated diagnoses of anemia (too little healthy red blood cells in the blood), anxiety, and constipation. Review of the clinical record indicated Resident R178 was transferred to the hospital on [DATE], and returned to the facility on [DATE]. Review of Resident R178'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 12/20/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R273 was admitted to the facility on [DATE]. Review of Resident R273's MDS dated [DATE], indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and dysphagia (difficult swallowing). Review of the clinical record indicated Resident R273 was transferred to the hospital on 9/23/25, and returned to the facility on [DATE]. Review of the clinical record revealed Resident R300 was admitted to the facility on [DATE]. Review of Resident R300's MDS dated [DATE], indicated diagnoses of dementia (decline in cognitive function, affecting memory, thinking, behaviors and the ability to perform everyday activities), anemia and cardiomyopathy (progressive heart disease characterized by the abnormal enlargement of the heart muscle). Review of the clinical record indicated Resident R300 was transferred to the hospital on 3/4/26. Review of Resident R300'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 3/4/26. During an interview on 3/11/26, at 10:44 a.m. Social Worker Employee E5 confirmed that there was no evidence that the State Ombudsman office was notified for Residents R9, R10, R55, R79, R178, R273, R300's transfer to the hospital. During an interview on 3/12/26, at 9:03 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of seven residents sampled with facility-initiated transfers (Residents R9, R55, R79, R178), failed to notify the resident or resident's representative of the facility bed-hold policy for one of seven resident hospital transfers (Resident R9), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for seven of seven resident hospital transfers (Resident R9, R10, R55, R79, R178, R273, R300). 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for four of 50 residents (Residents R2, R55, R273, and R280).Findings include: Review of facility policy Care Planning and Implementation dated 10/1/25, indicated each resident will have an individualized interdisciplinary care plan developed that addresses the residents' needs as they are discovered through the assessment process. Applying current standards of practice in the care planning process. Assessing and planning for care to meet the residents medical, nursing, mental, and psychosocial needs. Evaluating treatment of measurable objectives, timetables, and outcomes of care. Respect the resident's right to decline treatment. Offering alternative treatments, as applicable. Using an appropriate interdisciplinary approach to care plan development. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/26, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R2's physician orders dated 8/16/24, indicated that Resident R2 was to be transferred with a Hoyer lift, assist of two. Review of Resident R2's care plan dated 5/19/25, indicated transfers Hoyer lift, assist of two. Resident R2's care plan failed to indicate the kind of Hoyer pad and the Hoyer size to use when transferring resident. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's MDS dated [DATE], indicated high blood pressure, depression, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Resident R55's physician orders dated 2/3/26, indicated that Resident R55 was to be transferred with a Hoyer lift, assist of two, no ambulation. Review of Resident R55's care plan dated 3/9/26, indicated to assist with transfers and ambulation as ordered. Resident R55's care plan failed to indicate the use of Hoyer Lift for transfers, the kind of Hoyer pad, and the Hoyer size to use when transferring resident. Review of the clinical record indicated Resident R273 was admitted to the facility on [DATE]. Review of Resident R273's MDS dated [DATE], indicated diagnoses of cerebral infarction (necrotic (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tissue in the brain resulting loss of blood and oxygen to the brain), heart failure. and dysphagia (difficult swallowing). Review of Resident R273's physician orders dated 9/8/25, indicated that Resident R273 was to be transferred with a Hoyer lift, assist of two. No ambulation. Review of Resident R273's physician orders dated 9/2/25, indicated that Resident R273 receives Jevity 1.5 (a type of feeding that goes through a tube into stomach) at 65 milliliters(ml)/hour with 60 ml of water flush every hour for 24 hours. Review of Resident R273's physician orders dated 7/18/24, indicated that Resident R273's G-Tube (a tube that goes from the outside of the body to the stomach to provide nutrition) size is 20 French. Review of Resident R273's physician orders dated 9/4/24, indicated that Resident R273's trach (an opening in the neck and into the windpipe to provide an alternative airway for breathing) size is 60 xlt, shiley (kind of trach tube). Review of Resident R273's current care plan failed to be individualized, person-centered and failed to identify the kind of Hoyer pad, the correct size of Hoyer pad to use, the type of tube feeding, the size of G-Tube, and the size of trach tube. Resident R280's clinical record revealed an admission date of 1/21/25, with diagnoses including frostbite with necrosis (freezing of the tissue cells causing death to the tissue) of the left foot and right toes, morbid obesity (excess body fat significantly impacts daily functions and overall health), and psychoactive substance abuse, in remission (harmful or compulsive use of substances that alter brain function, affecting mood, perception, cognition, or behavior). Review of Resident R280's care plan entitled, Pain related to frostbite wounds included the following interventions initiated 1/22/25. Monitor/record/report any signs or symptoms of non-verbal pain such as changes in breathing, vocalizations (grunting, moans, yelling), mood/behavior changes, eyes and facial expression, body posture. Administer pain medications as per MD orders and note the effectiveness. Give as needed medications for breakthrough pain as per MD orders and note the effectiveness. There was no evidence that Resident R280's care plan for pain management included. Individualized, person-centered interventions (pharmacological and non-pharmacological). Included measurable objectives, interventions, and timeframes for how staff will meet Resident R280's needs. Resident R280's goals and desired outcomes. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Specialized services to be provided as a result of the comprehensive assessment. Resident R280's referral to the local contact agency. Any services that would otherwise be required but not provided due to the residents' right to refuse treatment, During an interview on 3/13/26, at 11:25 a.m. Director of Nursing confirmed that the facility failed to develop comprehensive care plans to meet resident care needs for Residents R2, R55, and R273. During an interview on 3/13/26, at 11:55 a.m. the Director of Nursing confirmed that Resident R280's care plan for pain management was not individualized and lacked the necessary interventions to provide person-centered care. 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility provided documents, and staff interviews, it was determined that the facility failed to ensure that a resident was free from a preventable accident during a transfer for one of three residents (R55), and failed to ensure that residents were free from potential accidents during a transfer for two of 46 residents (R2 and R273).Findings include: Review of the facility Accidents and Incidents policy dated 10/1/25, indicated that all accidents or incidents occurring on our premises must be investigated and reported to the administrator. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/26, indicated high blood pressure, depression, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Resident R55's physician orders dated 2/3/26, indicated that Resident R55 was to be transferred with a Hoyer lift, assist of two, no ambulation. Review of documentation provided by the facility identified as Nurse Aide (NA) Assignment Sheets on 3/10/26, indicated that resident R55 was transferred with Hoyer lift. Review of a written witness statement dated 3/2/26, from NA Employee E26 stated, At approximately 8:15 p.m., NA Employee E27 and I were preparing to transfer resident from her wheelchair to her bed via the Hoyer lift. As we were completing the transfer, resident slid out of the Hoyer and landed on her head. Nursing was immediately notified and resident was assessed and sent out to hospital for evaluation. No injuries occured. Review of an interview conducted by facility dated 3/3/26, at 11:40 a.m. with NA Employee E27 stated, NA Employee E26 were transferring Resident R55, and I checked the Hoyer pad, there were no tears or anything. The Hoyer seemed to be working fine. I noticed the resident was starting to slide and I told NA Employee E27 to hurry so we could get her to the bed before she fell out but didn't make it in time. Review of an interview conducted by the facility dated 3/3/26, at 12:00 p.m. with NA Employee E26 stated, Transferring resident with NA Employee E27. I set up her room and hooked her up to the blue straps. We lifted her out of her chair and moved her toward her bed when she slid out bottom first. I did not notice her sliding before it happened. They Hoyer pad was still attached to the hoyer after she fell. During an interview on 3/10/26, at 10:05 a.m. the Director of Nursing stated, The NA's used the Hoyer pad that had the legs cut out on and not the one-piece Hoyer pad that looks like a square during the Hoyer transfer and we replayed the scenario and did drawings and cannot figure out what went wrong. During a review of facility provided documentation labeled Hoyer on 3/10/26, at 1:10 p.m. indicated that 46 residents utilize a Hoyer Lift and Hoyer pad for transfers. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R2's physician orders dated 8/16/24, indicated that Resident R2 was to be transferred with a Hoyer lift, assist of two. Resident R2's physician orders failed to indicate what kind of Hoyer pad and what size of Hoyer pad to use that properly fit Resident R2. Review of Resident R2's care plan dated 5/19/25, indicated transfers Hoyer lift, assist of two. The care plan failed to have what kind of Hoyer pad and Hoyer size to use that are resident specific per resident's weight and height. Review of the clinical record indicated Resident R273 was admitted to the facility on [DATE]. Review of Resident R273's MDS dated [DATE], indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), heart failure. and dysphagia (difficult swallowing). Review of Resident R273's physician orders dated 9/8/25, indicated that Resident R273 was to be transferred with a Hoyer lift, assist of two. No ambulation. Resident R273's physician orders failed to indicate what kind of Hoyer pad and what size of Hoyer pad to use. Review of Resident R273's care plan dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/16/24, indicated transfers Hoyer lift, assist of two. Non-ambulatory. The care plan failed to have what kind of Hoyer pad and Hoyer size to use that are resident specific per resident's weight and height. During an interview on 3/10/26, at 10:30 a.m. NA Employee E29 stated, Takes two people to use a Hoyer lift. There are different kinds of Hoyer pads. I eyeball which color to use. I gauge the size. The sizes range from small to bariatric During an interview on 3/10/26, at 10:37 a.m. NA Employee E30 stated, We just kind of know the size of the Hoyer pad. When State Agency (SA) asked, Who designates what pad and size goes with a resident?, the NA Employee E30 responded That's a good question. I don't know. There are no care plans for the kind of Hoyer pad and its not on the Kardex. During an interview on 3/10/26, at 11:52 a.m. Rehab Director Employee E31 stated, Physical Therapy determines if a resident needs a Hoyer lift for transfers and they put the order in the residents medical record but we do not determine the kind and size of a Hoyer pad to use. During an interview on 3/11/26, at 10:05 a.m. the SA asked the Director of Nursing, How does staff know what kind of Hoyer pad or what size of Hoyer pad to use on a resident? The Director of Nursing stated, We don't have a process that determines this. During an interview on 3/13/26, at 9:32 p.m. Director of Nursing confirmed that the facility failed to ensure that a resident was free from a preventable accident during a transfer for one of three residents (R55), and failed to ensure that residents were free from potential accidents during a transfer for two of 46 residents (R2 and R273). 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(b)(1)(e)(1) Management. 28 Pa Code 201.29(a) Resident rights. 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 policies, clinical records and staff interview, it was determined that the facility failed to properly monitor weight and nutrition status by failing to obtain weights for four of seven residents (Resident R7, R82, R87, and R108), and failed individualize care plans to address the resident specific nutritional concerns for five of seven residents (Resident R3, R4, R79, R82, and R87).Findings include: Review of the facility policy Nutrition Management dated 10/1/25, indicated that residents will be weighed within 24 hours of admission. Residents will then be weighed weekly for four weeks, then monthly unless otherwise noted. Review of the facility policy MDS (minimum data set- periodic assessment of resident care needs) / RAI (resident assessment instrument- a standardized interdisciplinary system used to evaluate clinical status, functional ability, and care needs of residents) / Care Planning, dated 10/1/25, indicated that the facility will develop a written plan of care individualized for each resident, which identifies through an assessment process his/her strengths, problems, and needs. Review of the facility policy Care Planning and Implementation: dated 10/1/25, indicated that it is the responsibility of the Dietary Director to update the care plan when changes relative to the dietary needs of the resident occur. During morning meeting the Dietary Director will verify that all necessary care plan updates were completed during review of the 24-hour report. Any updates that were not previously completed will be completed during this review without delay. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident 3's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/8/25, indicated diagnoses of high blood pressure, hyperkalemia (high levels of potassium in the blood), and chronic pain. Review of Resident R3's clinical record revealed a physician's order dated 1/19/26, that stated to provide a Consistent Carb (diet for treatment of diabetes) Mechanical Soft texture (food is ground for ease in chewing), nectar liquids (liquids are thickened for ease in swallowing). Review of Resident R3's care plan last revised on 1/7/26, indicated that resident is at nutrition/hydration risk and interventions include the following: Provide diet/supplements per orders and honor food preferences as able. Monitor: weights, intakes, labs, skin signs and symptoms of dehydration. Notify the doctor with any significant changes. Review of Resident R3's care plan failed to include resident specific interventions for the physician ordered diet listed above. Review of the clinical record revealed that Resident R4 was admitted to the facility on [DATE]. (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 4's MDS dated [DATE], indicated diagnoses of high blood pressure, chronic pain, and kidney failure. Review of Resident R4's clinical record revealed a physician's order dated 9/5/25, to provide a Consistent Carb diet, regular texture, thin consistency, Renal (kidney) Control Shake daily. Review of Resident R4's care plan last revised on 10/3/25, indicated that resident is at nutrition/hydration risk and interventions include the following: Provide diet/supplements per orders and honor food preferences as able. Monitor: weights, intakes, labs, skin signs and symptoms of dehydration. Notify the doctor with any significant changes. Review of Resident R4's care plan failed to include resident specific interventions for the physician ordered diet listed above. Review of the clinical record revealed Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and Bipolar disorder (a mental condition marked by alternating periods of elation and depression). Review of Resident R7's weight record failed to reveal any documented weights for June 2025, July 2025, September 2025, and December 2025. Review of the clinical record revealed Resident R79 was admitted to the facility on [DATE]. Review of Resident R79'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 anxiety. Review of a physician order dated 12/23/25, indicated Renal diet, regular texture, thin consistency, Potassium restrictions to 75 mEq (milliequivalent), Protein 90 grams, 2 gram NA (sodium), no seeds, nuts, hulls. Review of Resident R79's comprehensive care plan indicated the resident is a nutrition/hydration risk related to: hyperkalemia (high levels of potassium in the blood), ESRD on HD (hemodialysis), T2DM (type 2 diabetes mellitus), FTT (failure to thrive), and edema. Interventions included provide diets/supplements per orders and honor food preferences as able. No seeds, nuts, hulls. 1500 mL (milliliter) fluid restriction. Fluid restriction as directed nursing 780 mL, dietary 720 mL. Review of Resident R79's care plan failed to include resident specific interventions for the physician ordered diet listed above. Review of Resident R79's active physician orders failed to include an order for a fluid restriction. During an interview on 3/12/26, at 11:25 a.m. Assistant Director of Nursing (ADON) Employee E8 confirmed Resident R79 is not currently ordered a fluid restriction and that the facility failed to revise the resident's care plan to address the resident specific nutritional concerns. (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 the clinical record revealed that Resident R82 was admitted to the facility on [DATE]. Review of Resident 82's MDS dated [DATE], indicated diagnoses of high blood pressure, stroke (disruption of blood supply to the brain), and reduced mobility. Review of Resident R82's clinical record revealed a physician's order dated 9/2/25, to provide enteral feed (liquid feeding administered through a tube in the stomach) of Jevity 1.2 at 70 milliliters (ml) per hour with 35 ml water flush every hour. Review of Resident 82's care plan last revised on 12/25/25, indicated that resident is at nutrition/hydration risk and interventions include the following: Provide TF (tube feeding) per orders Monitor: weights, TF tolerance labs, skin signs and symptoms of dehydration. Notify the doctor with any significant changes. Review of Resident 82's care plan failed to include resident specific interventions for the physician ordered diet/enteral tube feed listed above. Review of Resident R82's clinical record revealed the last weight recorded was on 12/1/25 at 169.8 pounds Review of clinical record revealed no monthly weight was obtained in January or February of 2026. Review of clinical record revealed that Resident R87 was admitted to the facility on [DATE]. Review of Resident 87's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and stroke. Review of Resident R87's clinical record revealed a physician's order dated 9/2/25, to provide enteral feed of Osmolite 1.2 at 55 ml per hour with 35 ml water flush every hour. Review of Resident 87's care plan last revised on 2/26/26, indicated that resident is at nutrition/hydration risk and interventions include the following: Provide TF (tube feeding) per orders Monitor: weights, TF tolerance labs, skin signs and symptoms of dehydration. Notify the doctor with any significant changes. Review of Resident 87's care plan failed to include resident specific interventions for the physician ordered diet/enteral tube feed listed above. Review of Resident R87's clinical record revealed that resident was not weighed in January 2026. Review of the clinical record revealed Resident R108 was admitted to the facility on [DATE]. (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 R108's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Bipolar disorder (a mental condition marked by alternating periods of elation and depression), and anxiety. Review of Resident R108's weight record failed to reveal any documented weights for December 2025 and January 2026. Review of a physician order dated 2/18/26, indicated weekly weights x 4 weeks one time a day every Wednesday for health maintenance. Review of Resident R108's clinical record failed to reveal documentation that the resident was weighed on 2/18/26, and 2/25/26. During an interview on 3/12/27, at 12:17 p.m. the Director of Nursing confirmed that the facility failed to monitor weights for Resident R7, R82, R87, and R108 by not obtaining monthly weights as required. During an interview on 3/12/27, at 2:05 p.m. the DON confirmed that the facility failed to individualize care plans to address the resident specific nutritional concerns for Resident R3, R4, R79, R82, and R87. 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for seven of seven residents (Residents R5, R6, R17, R87, R108, R124, and R190). Findings include: Review of the facility policy Enabler Bars last reviewed 10/1/25, indicated the use of enabler bars or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of enabler bars have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/21/25, indicated diagnoses of diabetes (high sugar in the blood), hyperlipidemia (high fat in the blood) and anxiety. Review of Resident R5's physician orders dated 8/30/24, indicated bilateral (both sides) bed enablers to aid in independence with bed positioning. During an observation on 3/12/26, at 10:58 a.m. bilateral side rails were observed on the top of Resident R5's bed. Review of Resident R5's clinical record revealed enabler bar assessments were completed for 2/9/26, and 3/11/26, no prior assessments were completed. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and schizophrenia (a serious mental health condition that affects thinking, feeling and behavior). Review of Resident R6's physician orders dated 1/22/25, indicated bilateral bed enablers to increase independence with bed positioning, absence of left leg below knee. During an observation on 3/12/26, at 11:01 a.m. bilateral side rails were observed on the top of Resident R6's bed. Review of Resident R6's clinical record revealed enabler bar assessments were completed for 1/8/23, 2/9/26, and 3/11/26, no other assessments were completed. During an interview completed on 3/12/26, at 11:03 a.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that Resident R5 and Resident R6 did not have bedrail assessments to ensure that (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedrails were used to meet residents' needs and the risks associated with bedrail usage and stated I was not aware that the side rail assessments were needed, I just started to do them. Review of the clinical record revealed Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's MDS dated [DATE], indicated diagnoses of high blood pressure, obstructive uropathy (condition in which urine flow is blocked), and hemiparesis (one-sided muscle weakness, often caused by stroke or brain injury). Review of a physician order dated 11/2/23, indicated bilateral (both sides) bed enabler bar to aid in bed mobility with diagnosis of left hemiparesis.During an observation on 3/9/26, at 11:10 a.m. bilateral enabler bars were observed on the top of Resident R17's bed. Review of Resident R17's clinical record failed to reveal an ongoing accurate assessment for the resident's enabler bar usage. Review of clinical record revealed that Resident R87 was admitted to the facility on [DATE]. Review of Resident 87's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and stroke (disruption of blood supply to the brain). During an observation on 3/11/26, at 12:34 p.m. Resident R87 had enabler bars to both sides of her bed. Review of clinical record failed to reveal a physician's order to apply enabler bars to the bed, or any assessment to ensure that Resident R87 was safe to utilize enabler bars. During an interview on 3/11/26, at 12:38 p.m. LPN Employee E32 stated that Resident R87 is not physically or mentally able to utilize the enabler bars. During an interview on 3/12/26, at 9:50 a.m. Assistant Director of Nursing (ADON) Employee E8 stated that the enabler bars were applied to Resident R87's bed without an order or assessment and would be removed for safety. Review of the clinical record revealed Resident R108 was admitted to the facility on [DATE]. Review of Resident R108's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), bipolar disorder (a mental condition marked by alternating periods of elation and depression), and anxiety. Review of a physician order dated 9/23/25, indicated patient to have bilateral enabler bars to increase independence with bed mobility. During an observation on 3/9/26, at 10:07 a.m. bilateral enabler bars were observed on the top of Resident R108's bed. Review of Resident R108's clinical record failed to reveal an ongoing accurate assessment for the resident's enabler bar usage. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident R124 was admitted to the facility on [DATE]. Review of Resident R124's MDS dated [DATE], indicated diagnoses of aphasia (language disorder that affects communication), epilepsy (disorder of the brain characterized by repeated seizures), and anoxic brain injury (occurs when the brain is deprived of oxygen, leading to damage or deal of brain cells).During an observation on 3/9/26, at 10:17 a.m. bilateral padded enabler bars were observed on the top of Resident R124's bed. Review of Resident R124's active physician orders failed to include an order for bilateral padded enabler bars. Review of Resident R124's clinical record on 3/11/26, failed to include an ongoing assessment for the resident's padded enabler bar usage, and failed to include the development of goals and interventions related to the resident's padded enable bar usage in the comprehensive care plan. Review of the clinical record revealed Resident R190 was admitted to the facility on [DATE]. Review of Resident R190's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and dementia. Review of a physician order dated 9/19/25, indicated patient to have bilateral enabler bars on bed to increase independence with bed mobility. During an observation on 3/9/26, at 11:04 a.m. bilateral enabler bars were observed on the top of Resident R190's bed. Review of Resident R190's clinical record failed to reveal an ongoing accurate assessment for the resident's enabler bar usage. During an interview on 3/12/26, at 9:53 a.m. ADON Employee E8 confirmed that the facility failed maintain accurate resident care plans for Resident R124 and failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for Residents R17, R108, R124, and R190. 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 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 clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews (MRRs) were completed by the facility for five of seven residents (Resident R3, R6, R97, R133 and R137), and failed to ensure MRRs were reviewed by the resident's attending physician monthly for one of seven residents (Resident R7).Findings include: The Pharmacy Service policy last reviewed 10/1/25, indicated the nursing home shall have pharmaceutical services that meet the needs of the residents. A licensed pharmacist will review the drug regimen reviews of each resident at least monthly. The pharmacist will report any irregularities to the attending physician and the Director of Nursing (DON) they will sign off and/or address the report in their progress note. Review of the clinical record indicated Resident R97 was admitted to the facility on [DATE]. Review of Resident R97's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/22/26, indicated diagnoses of multiple sclerosis (autoimmune disease that affects the central nervous system), dementia (decline in cognitive function, affecting memory, thinking, behaviors and the ability to perform everyday activities) and anxiety. Review of Resident R97's MRR indicated the following: November 2025 - facility failed to provide the completed MRR by attending physician December 2025 - facility failed to provide the completed MRR by attending physician Review of the clinical record indicated Resident R133 was admitted to the facility on [DATE]. Review of Resident R133's MDS dated [DATE], indicated diagnoses of anoxic brain damage, adult failure to thrive and dementia (decline in cognitive function, affecting memory, thinking, behaviors and the ability to perform everyday activities). Review of Resident R133's MRR indicated the following: October 2025- facility failed to provide the completed MRR by attending physicianNovember 2025 - facility failed to provide the completed MRR by attending physician Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/8/25, indicated diagnoses of high blood pressure, hyperkalemia (high levels of potassium in the blood), and chronic pain. Review of Resident R3's care plan indicated that the resident requires use of psychotropic medication and is at risk for adverse side effects. Review of Resident R3's clinical progress notes did not include a pharmacy notation or review by a (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	licensed pharmacist for August 2025, and November 2025. Review of the clinical record indicated Resident R6's was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS -a periodic assessment of resident care needs) dated 2/2/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and schizophrenia (a serious mental health condition that affects thinking, feeling and behavior). Section N045 A. Antipsychotic: coded yes, indicated resident is taking an antipsychotic medication. Review of Resident R6's physician order dated 11/13/24, indicated monitor resident for side effects of psychotropic usage: dystonia, dry mouth, tardive dyskinesia, increase in gait disturbance, somnolence. If side effects are present document assessment in progress note and notify physician every shift. Review of Resident R6's clinical record failed to include any documentation that pharmacy medication regimen reviews were completed by a licensed pharmacist. During a clinical record review and interview completed on 3/13/26, at 9:42 a.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that Resident R6's clinical record failed to include any MRR's completed by a licensed pharmacist and stated, I know there was an issue with them. Review of the clinical record indicated Resident R137 was admitted to the facility on [DATE]. Review of Resident R137's' Minimum Data Set (MDS -a periodic assessment of resident care needs) dated 2/16/26, indicated diagnoses of high blood pressure, anxiety disorder and depression. Section N0415 A. Antipsychotic coded yes indicated resident is taking an antipsychotic. B. Antianxiety coded yes indicated resident is taking an antianxiety medication. C. Antidepressant medication coded yes indicated resident is taking an antidepressant medication. Review of Resident R137's physician orders dated 11/13/24, indicated monitor resident for side effects of psychotropic usage: dystonia, dry mouth, tardive dyskinesia, increase in gait disturbance, somnolence. If side effects are present, document assessment in progress note and notify physician. Review of Resident R137's clinical record failed to include any documentation that pharmacy medication regimen reviews were completed by a licensed pharmacist. During a clinical record review and interview completed on 3/13/26, at 9:42 a.m. Registered Nurse (RN) Employee E15 confirmed that Resident R137's clinical record failed to include any MRR's completed by a licensed pharmacist and stated, we were having an issue with them they just started back within a month or two. Review of the clinical record revealed Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and Bipolar disorder (a mental condition marked by alternating periods of elation and depression). Review of Resident R7's MRR dated 1/23/26, indicated the following recommendation from the pharmacist to the physician: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Recommend discontinuation/re-evaluation of the following PRN (as needed) psychotropic agent(s) per following Federal Guideline: PRN Lorazepam (a medication used to treat anxiety). Review of Resident R7's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/23/26. On 2/24/26, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, continue medication, will enter new order, put focus on comfort/quality of life.Review of a follow up progress note dated 2/27/26, completed by CRNP Employee E25 stated, Continue PRN Ativan (Lorazepam) 0.5 mg (milligrams) q6 (every 6 hours) prn x 120 days - med effective for anxiety, with pt (patient) current focus of comfort and quality of life psychology and mind care. During an interview on 3/12/26, at 12:26 p.m. the Director of Nursing (DON) confirmed that the facility failed to ensure medication regimen reviews were reviewed by the resident's attending physician monthly for Resident R7 and that the facility failed to ensure that MRR were completed monthly for Resident R3, R6, R97, R133, R137. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.5(f) Medical records. 28 Pa. Code: 211.9(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(3)(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 policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in three of four medication rooms (2 East Medication Room, 3 East Medication Room, and 5 Main Medication Room), and one of eight medication carts (3 East units [NAME] Hall Medication Cart) and failed to properly secure one of eight medication carts (3 East units [NAME] Hall Medication Cart) while not in use.Findings include: Review of facility policy Storage of Medications dated 10/1/25, indicated medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. No discontinued, outdated or deteriorated medications are available for use in the facility. All such medications are destroyed. Compartments containing medications are locked when not in use. During an observation on 3/9/26, at 12:32 p.m. of the 5 Main Medication Room, an opened bottle of tuberculin solution (a medication administered to test for tuberculosis) was observed in the medication room refrigerator with no open date. During an interview on 3/9/26, at 12:32 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the above observation and that the facility failed to properly store medications in the 5 Main Medication Room. During an observation completed on 3/10/26, at 9:08 a.m. the 2 East medication rooms refrigerator contained the following: 1 opened bottle of Fluphenazine Deconate (long-acting antipsychotic) opened and without a date. 1 box Afluria Influenza Vaccine containing 12 syringes with the expiration date of 5/25. 1 white unlabeled ice pack in freezer During an interview completed on 3/10/26, at 9:16 a.m. Licensed Practical Nurse (LPN) Employee E 16 Confirmed the above observations and that the facility failed to properly store medications in the 2 East medication room. During an observation completed on 3/10/26, at 9:52 a.m. the 3 East Medication rooms bottom cupboard to right of the sink contained: An opened package of Oreo cookies An opened box of moon pies An opened package of iced oatmeal cookies An opened package of animal crackers An opened bag of pretzels (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The upper cupboard on the left wall contained: An opened perfume bottle 2 cups of instant noodles The medication room refrigerator had a brown substance on the inside bottom and a black substance around the seal. During an interview completed on 3/10/26, at 9:54 a.m. Registered Nurse RN Employee E15 confirmed the above observations and stated, the snacks are from the staff they bring things in, I have no idea whose perfume or noodles those are and that the facility failed to properly store medications in the 3 East Medication room. During an observation completed on 3/11/26, at 9:10 a.m. the 3 East unit's [NAME] side medication cart contained the following: One Lantus insulin pen opened and not labeled with a date as required. During an interview completed on 9/11/26, at 9:12 a.m. Licensed Practical Nurse (LPN) Employee E21confirmed the Lantus insulin was opened and not labeled with a date as required and that the facility failed to properly store medications in the 3 East unit's [NAME] side medication cart. During an observation completed on 3/10/26, at 9:56 a.m. the 3 East unit's [NAME] side medication cart was left unattended and unlocked outside of room [ROOM NUMBER]. During an interview completed on 3/10/26, at 9:57 a.m. LPN Employee E21 confirmed the medication cart was left unattended and unlocked and that the facility failed to properly secure the 3 East units [NAME] Hall Medication Cart. 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on review of facility policy, observation, and staff interview it was determined that the facility failed to properly contain and dispose of garbage in two of two outside dumpsters to prevent the potential for rodent and insect infestation (dumpster one, and dumpster two).Findings include: Review of the facility policy Garbage and Rubbish Disposal, dated 10/1/25, indicated that outside dumpsters provided by the garbage pick-up services must be kept closed and free of litter around the dumpster area. During an observation and interview of the facility's outdoor trash receptacles on 3/10/26, at 1:30 p.m. Dietary Manager Employee E19 confirmed that the lid/cover was not closed on dumpster one, and dumpster two, and that the facility failed to properly contain and dispose of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation. 28 Pa. Code 201.18(b)(3) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to prevent cross contamination during a dressing change for one of two residents (Resident R293), failed to prevent cross contamination during a medication pass for one of three residents (Resident R248) and failed to implement appropriate transmission-based precautions for three of six residents (Residents R18, R111 and R276). Review of the facility policy Enhanced Barrier Precautions (EBP) last reviewed 10/1/25, indicated Enhanced Barrier precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). Enhanced barrier precautions are to be implemented for residents with an infection or colonization with a MDRO, wounds and or indwelling medical devices. An enhanced barrier precaution sign will be displayed near the entrance of the room. Review of the facility policy Wound Care dated 10/1/25, indicated the facility follows physician orders to maintain the highest level of comfort and promote healing of wounds. Discard old dressing and gloves in a plastic bag. Perform hand hygiene. Put on clean gloves to apply new dressing. Review of the facility policy Hand Hygiene/Handwashing dated 10/1/25, indicated effective hand hygiene reduces the incidence of healthcare-associated infections. Wash hands when hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood, or other body fluids. Review of the admission record indicated Resident R248 was admitted to the facility on [DATE]. Review of Resident R248's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/22/26, indicated the diagnosis of high blood pressure, diabetes (high sugar in the blood) and seizure disorder (disrupts movement, awareness and sensation). Review of Resident R248's current physician orders indicated Depakote sprinkles oral capsules 125 milligram (mg) give two capsules by mouth two times a day related to seizures During an observation completed on 3/11/26, at 9:26 a.m. Licensed Practical Nurse (LPN) Employee E21 was preparing Resident R248's medications. LPN Employee E21 placed Resident R248's Depakote sprinkle capsules into a separate medication cup. LPN Employee E21 then placed a small amount of pudding into another medication cup, using bare hands plucked the capsules out of the other medication cup, opened the capsules and sprinkled the medication into the pudding. During an interview completed on 3/11/26, at 9:31 a.m. LPN Employee E21 confirmed touching and opening Resident R248's Depakote sprinkle capsules without completing hand hygiene or utilizing gloves. Review of the admission record indicated Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's MDS dated [DATE], indicated the diagnosis of high blood pressure, anemia (low iron in the blood) and depression. Section M0100 Pressure Ulcer/Injury risk: A. checked box that indicated resident has a pressure ulcer/injury. Review of Resident R111's physician order dated 12/19/25, indicated enhanced barrier precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(EBP). Resident with presence of wound. Staff to wear gloves and gowns for high contact resident care: Dressing, bathing, transferring, changing linen, toileting/hygiene care, device/line care, wound care. Review of Resident R111's current care plan indicated enhanced barrier precautions. Resident with presence of wound. Staff to wear gloves and gown for high contact resident care: Dressing, bathing, transferring, changing linen, toileting/hygiene care, device/line care, wound care Observation completed on 3/9/26, at 10:30 a.m. Resident R111's room door had a bin hanging on it containing personal protective equipment (PPE). The door failed to include an enhanced barrier precaution sign near the entrance of the room. Review of the admission record indicated Resident R276 was admitted to the facility on [DATE]. Review of Resident R276's MDS dated [DATE], indicated the diagnosis of high blood pressure, diabetes (high sugar in the blood) and renal insufficiency (reduced kidney function). Section H0100 Bladder and bowel appliances: C checked box that indicated resident has an ostomy (including (urostomy, ileostomy, and colostomy). Review of Resident R276's physician orders dated 1/28/25, indicated Enhanced barrier precautions. Resident with presence of urostomy. Staff to wear gloves and gowns for high contact resident care: Dressing, bathing, transferring, changing linen, toileting/hygiene care, device/line care, wound care. Review of Resident R276's current care plan indicated resident with presence of urostomy requiring enhanced barrier precautions. Staff to wear gowns and gloves for high contact resident care activities: dressing, bathing, transferring, changing linen, providing hygiene, changing briefs/toileting, device or line care, wound care. Observation completed on 3/9/26, at 10:30 a.m. Resident R111's room door had a bin hanging on it containing personal protective equipment (PPE). The door failed to include an enhanced barrier precaution sign near the entrance of the room. During an interview completed on 3/9/26, at 10:45 a.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that Resident R111 and Resident R276's rooms failed to include an enhanced barrier precaution sign near the entrance of the room. Resident R18's clinical record revealed an admission date of 7/16/25, with diagnoses including intellectual disabilities, urinary incontinence, physical debility, and progressive neuropathy (nerve disorder of an unknown cause that worsens over time, leading to sensory, motor, and sometimes autonomic dysfunction). Resident R18's physician's orders dated 10/20/25, for enhanced barrier precautions due to the presence of a foley catheter and that staff are to wear gloves, and gown for high contact resident care including device care. Observation on 3/10/26, at 10:15 a.m. of urinary catheter care for Resident R18 revealed Nurse Aid (NA) Employee E33 failed to don a protective gown while performing care. During an interview at that time NA Employee E33 confirmed that he/she does not wear a protective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown during catheter care unless the resident has an infectious organism in their urine. Interview on 3/10/26, at 10:40 a.m. the Director of Nursing confirmed that NA Employee E33 should have worn a protective gown while providing catheter care to Resident R18. Review of the clinical record indicated Resident R293 was admitted to the facility on [DATE]. Review of Resident R293's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/26, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During a review of Residents R293's physician orders dated 1/6/26, indicate to cleanse wound to left buttocks with vashe (a type of wound cleanser), apply Santyl (a chemical agents for removing dead skin cells), nickel thick, then alginate (a highly absorptive dressing that creates a protective gel and maintains a moist wound environment), and cover with dressing every day shift. During a wound care dressing change observation on 3/12/26, at 11:40 a.m. Registered Nurse (RN) Employee E12 entered Resident R293's room to complete a dressing change. RN Employee E12 cleaned the bedside table, placed a clean barrier down, and placed the dressing supplies on the barrier. RN Employee E12 then removed the old dressing and placed it in dirty plastic bag. RN Employee E12 cleansed the wound with vashe and threw away the dirty supplies. RN Employee E12 failed to remove gloves and perform hand hygiene prior to applying clean wound care treatment to the left buttocks wound. During an interview on 3/12/26, at 11:50 a.m. RN Employee E12 confirmed the failure to perform hand hygiene during Resident R293's dressing change. During an interview on 3/12/26, at 11:54 a.m. Assistant Director of Nursing Employee E13 confirmed that the facility failed to prevent cross contamination during a dressing change for one of two residents (Resident R293). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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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 two of five residents (Residents R17 and R298).Findings include: Review of facility policy Resident Rights dated 10/1/25, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the clinical record revealed Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/26, indicated diagnoses of high blood pressure, obstructive uropathy (condition in which urine flow is blocked), and hemiparesis (one-sided muscle weakness, often caused by stroke or brain injury). Review of a physician order dated 2/13/26, indicated 16 French (catheter size) foley catheter with 5 cc (cubic centimeter, unit of volume measurement) balloon for other obstructive and reflux uropathy.During an observation on 3/9/26, at 11:10 a.m. Resident R17's foley catheter collection bag was observed partially full of urine, hanging on the right side of the bed, facing the entrance of the room, without a privacy cover applied.During an interview on 3/9/26, at 11:23 a.m. Nurse Aide Employee E3 confirmed Resident R17's catheter collection bag did not have a privacy cover and that the facility failed to ensure that care was provided in a manner in which maintained Resident R17's dignity. Review of the clinical record revealed Resident R298 was admitted to the facility on [DATE]. Review of Resident R298's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), depression, and cachexia (metabolic disorder characterized by the severe, involuntary loss of skeletal muscle mass and fat). Review of a physician order dated 10/16/25, indicated upright or OOB (out of bed) for all meals and full feed (staff to feed) to ensure adequate nutrition and safety. During an observation on 3/9/26, at 12:36 p.m. Resident R298 was observed sitting in the 5 Main dining room at a table. A meal tray was observed sitting on the table next to the resident. Another resident was sitting across from Resident R298 eating their lunch. During an interview on 3/9/26, at 12:44 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R298 is a staff feed and was waiting in the dining room to be fed their lunch. During an interview on 3/9/25, at 12:44 p.m. LPN Employee E1 confirmed that the facility failed to provide a dignified dining experience for Resident R298. Pa. Code: 201.14(a) Responsibility of licensee.Pa. Code: 211.10(d) Resident care policies.Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **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 maintain residents' confidential personal and medical records for one of five residents (Resident R3). Findings include: A review of the facility policy titled, Resident Rights dated 10/1/25, indicated that residents have the right to privacy in treatment and personal care. Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/8/25, indicated diagnoses of high blood pressure, hyperkalemia (high levels of potassium in the blood), and chronic pain. During an observation on 3/10/26, at 9:18 a.m. a sign was observed posted on Resident R3's wall above the bed that included the following information: Nectar thick liquids, no thin liquids. Review of Resident R3's clinical record failed to include any documentation that the above residents or their representatives approved the posting of private health information. During an interview on 3/12/26, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to maintain residents' confidential personal and medical records for one of five residents (Resident R3). 28 Pa. Code: 201.18(e)(1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Resident Assessment Instrument (RAI) User Manual, clinical records, and staff interview, it was determined that the facility failed to ensure Minimum Data Set (MDS- a periodic assessment of care needs) accurately reflected the resident's status for two of seven residents (Resident R15, R13). Findings include: Review of MDS instructions for Section N Medications N0415F, Antibiotics is to be checked if the resident is taking any medications by pharmacological classification during the last seven days or since admission/entry or reentry if less than 7 days. Resident R13's clinical record revealed an admission date of 12/30/24, with diagnoses including stroke, difficulty speaking, left-sided weakness, and human immunodeficiency virus. Resident R13's Annual MDS with an Assessment Reference Date (ARD) of 1/06/26, Section N0415F was coded yes receiving antibiotics admission/entry or reentry if less than 7 days. Residents R13's clinical record lacked evidence that he/she had received antibiotics admission/entry or reentry if less than 7 days. Interview on 3/12/26, at 9:45 a.m. the Director of Utilization Review confirmed that Resident R13's Annual MDS ARD of 1/06/26, Section N0514F was coding incorrectly for receiving antibiotics. Review of Resident R15's admission record indicated he was admitted [DATE]. Review of Resident R15's MDS assessment (Minimum Data Set MDS- a periodic assessment of care needs) dated 2/4/26, indicated that he had diagnoses included dementia (decline in cognitive function, affecting memory, thinking, behaviors and the ability to perform everyday activities), chronic kidney disease and hyperlipemia. Review of Resident R15's MDS assessment completed 2/4/26, Section E900-Wandering indicated a 2. resident has wandered in the last 4-6 days. Review of Resident R15's physician orders 1/9/26, did not include a wander guard. Review of Resident R15's progress notes dated 1/1/26- 2/4/26 indicated no wandering behavior. Review of Resident R15'2 Elopement Risk assessment dated [DATE] indicated a score of 0, no risk of elopement. During an interview on 3/12/26, at 10:20 a.m. Utilization Review Director Employee E24 confirmed that the facility failed to ensure Minimum Data Set assessment (MDS) accurately reflected Resident R15's status as required. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **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 incorporate the recommendations from the Pre-admission Screening and Resident Review (PASARR) level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for one of three residents reviewed (Resident 65).Findings include: Review of the clinical record revealed that Resident R65 was admitted to the facility on [DATE]. Review of Resident 65's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/10/26, indicated diagnoses of bipolar disorder (a mental condition marked by alternating periods of elation and depression), anxiety, and depression. Further review of Resident 65's clinical record revealed a PASARR Level I (federally required assessment to help ensure that all individuals with serious mental disorders and/or intellectual disabilities are not inappropriately placed in nursing homes for long term care) dated 5/25/16 with the following outcome: Individual has a positive screen for Serious Mental Illness, Intellectual Disability, and/or Other Related Condition; requires further evaluation (Level II). A PASARR Level II determination letter dated 5/27/16, indicated that, the resident had been determined eligible for the level of services provided by a nursing facility and may be admitted or continue to reside in a nursing facility enrolled in the Department's Medicaid (MA) Program. The nursing facility must provide or arrange for provision of mental health services for any resident with mental illness who needs such services. Such services include: preparation of systematic plans which are designed to facilitate appropriate behavior, drug therapy and monitoring for effectiveness and side effects, structured social activities, the teaching of daily living skills to enhance self-determination and independence, Individual/group/family therapy, and/or personal support networks and formal behavior modification programs as determined by and provided by qualified personnel. During an interview on 3/11/26, at 11:01 a.m. Social Services Director (SSD) Employee E5 confirmed that the PA-PASARR II form completed had identified Resident 65 as a target resident, and that no more recent documentation existed to absolve resident from meeting the requirements. SSD Employee E5 confirmed that the facility failed to provide coordination of the provision of specialized services for Resident R65. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services28 Pa. Code 211.5(f) Clinical Records

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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. **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 include hyperglycemic (high blood sugar) protocols for one of three residents (Resident R6).Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and schizophrenia (a serious mental health condition that affects thinking, feeling and behavior). Review of Resident R6's physician orders dated 11/18/25, indicated Accu-check's (measures blood glucose levels using small blood sample on a test strip) every day and evening shift. Review of Resident R6's physician order dated 11/20/25, indicated Glucose Gel 40 % (Dextrose and water that quickly raises blood sugar levels) give 1 applicator full by mouth as needed for hypoglycemia (low blood sugar) of less than or equal to 70 milligrams/deciliter (mg/dl) in patients who are asymptomatic or symptomatic and able to swallow. Re-Check blood sugar in 10-15 minutes may repeat x1. Review of Resident R6's physician orders dated 11/24/25, indicated Zegalogue Subcutaneous Solution (used to treat low blood sugar much faster than glucose gel) prefilled syringe 0.6 milligram/0.6 milliliter (MG/ML). Inject 1 syringe subcutaneously as needed for diabetes give if blood glucose is less than or equal to 70 mg/dl who are unresponsive or cannot swallow. Re-Check blood sugar in 10-15 minutes. May repeat x1. Review of Resident R6's physician orders failed to include measures for hyperglycemia (high blood sugar) During an interview completed on 3/13/26, at 9:42 a.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that Resident R6's physician orders failed to include measures for hyperglycemia and stated he is twice a day checks, they are in for hypoglycemia, I will fix it now and confirmed that the facility failed to include hyperglycemic protocols for one of three residents (Resident R6). 28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.29(d) Resident rights28 Pa. Code 211.10 (c)(d) Resident care policies28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers (PU/PIs - injuries to skin and underlying tissue resulting from prolonged pressure on the skin), and failed to develop a plan of care timely for one of four residents (Resident R108).Findings include:Review of facility policy Pressure Ulcer - Prevention and Treatment dated 10/1/25, indicated residents will receive skin care, repositioning and nutritional support to assist in preventing the development of avoidable pressure ulcers. Routine preventative and daily care will be provided to prevent avoidable pressure ulcers. Routine preventative care means turning and proper positioning, application of pressure reduction or relief devices, providing good skin care (i.e., keeping the skin clean, instituting measures to reduce excessive moisture, applying lotion), providing clean and dry bed linens, and maintaining adequate nutrition and hydration as possible. The care plan will identify the resident as being at risk for pressure sore(s) and provide aggressive/appropriate preventative measures and care specific to addressing the resident's unique risk factors. Preventative care plan implemented consistently and monitored and evaluated resident's response to preventative measures. Review of the clinical record revealed Resident R108 was admitted to the facility on [DATE]. Review of Resident R108's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), bipolar disorder (a mental condition marked by alternating periods of elation and depression), and anxiety. Question M0150 was coded 1 yes, resident is at risk of developing pressure ulcers/injuries. Review of a physician order dated 11/13/25, indicated bilateral (both sides) offloading boots to be worn in bed as tolerated to decrease risk of skin breakdown. During an observation on 3/9/26, at 10:56 a.m. Resident R108 was observed lying in bed without their bilateral offloading boots on. During this observation, Resident R108 stated, Staff will put the boots on once in a while.During an interview on 3/9/26, at 11:21 a.m. Licensed Practical Nurse Employee E2 confirmed Resident R108 did not have their bilateral offloading boots applied and that the facility failed to make certain Resident R108 was provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers.Review of Resident R108's comprehensive care plan on 3/11/26, failed to include measurable goals and interventions related to the usage of bilateral offloading boots.During an interview on 3/12/26, at 11:25 a.m. Assistant Director of Nursing Employee E8 confirmed that the facility failed to develop a plan of care timely for measurable goals and interventions related to prevention of pressure ulcer development for Resident R108. 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)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 receives appropriate services, equipment, and assistance to maintain or improve mobility and failed to develop and revise a comprehensive resident-specific plan of care for a resident with limited mobility requiring equipment and assistance to maintain or improve mobility for two of five residents (Residents R124 and R307).Findings include: Review of facility policy Care Planning and Implementation dated 10/1/25, indicated each resident will have an individualized interdisciplinary care plan developed that addresses the resident's needs as they are discovered through the assessment process. The overall care plan will be oriented towards preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation), applying current standards of practice in the care planning process, evaluating treatment of measurable objectives, timetables and outcomes of care, and using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. Review of the clinical record revealed Resident R124 was admitted to the facility on [DATE]. Review of Resident R124's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/26, indicated diagnoses of aphasia (language disorder that affects communication), epilepsy (disorder of the brain characterized by repeated seizures), and anoxic brain injury (occurs when the brain is deprived of oxygen, leading to damage or deal of brain cells). Review of a physician order dated 1/6/26, indicated patient to have rolled washcloths or palm guards (a brace used to prevent finger contractures and skin break down in the palm) in bilateral (both sides) hands as tolerated with daily skin checks and hand hygiene.During an observation on 3/9/26, at 10:16 a.m. Resident R124 was observed lying in bed and did not have bilateral palm guards applied or rolled washcloths in their hands.During an observation on 3/9/26, at 12:09 p.m. Resident R124 was observed lying in bed and did not have bilateral palm guards applied or rolled washcloths in their hands.During an interview on 3/9/26, at 12:33 p.m. Licensed Practical Nurse Employee E2 confirmed Resident R124 did not have bilateral palm guards applied or rolled washcloths in their hands and that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility.Review of Resident R124's comprehensive care plan on 3/10/26, revealed the resident had physical mobility impaired and the potential for increased contractures, especially of LE (lower extremities) and will not develop increase in contractures to her upper and lower extremities. Interventions included soft external dorsiflexion braces 4 hours on/off with regular skin checks. The care plan did not include measurable goals and interventions related to the usage of bilateral palm guards or rolled washcloths.Review of Resident R124's active physician orders did not include an order for soft external dorsiflexion braces.During an interview on 3/12/26, at 11:25 a.m. Assistant Director of Nursing (ADON) Employee E8 stated, The soft external dorsiflexion braces were discontinued in January. During this interview, ADON Employee E8 confirmed that the facility failed to develop and revise a comprehensive resident-specific plan of care for a resident with limited mobility requiring equipment and assistance to maintain or improve mobility for Resident R124. Review of clinical record revealed that Resident R307 was admitted to the facility on [DATE]. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 307's MDS indicated diagnoses of high blood pressure, hemiparesis (mild to moderate weakness, numbness, or reduced control on one side of the body), and chronic pain. Review of a physician order dated 12/17/24, indicated that resident is to wear resting hand splint to left upper extremity to be put on before breakfast. and removed at lunch. During an observation on 3/12/26, at 9:16 a.m. Resident R307 was resting in bed and noted to not have a resting hand splint applied. During an interview on 3/12/26, at 9:16 a.m. Resident R307 stated that she tolerates her splint well, but that it isn't always applied by staff. During an interview on 3/12/26, at 9:20 a.m. Licensed Practical Nurse (LPN) E28 confirmed that Resident R307 did not have her resting hand splint on as ordered. Review of Resident R307's comprehensive care plan did not include any interventions for left side weakness and use of resting hand splint on left upper extremities. During an interview on 3/12/25, at 10:30 a.m. ADON Employee E8 confirmed that the facility failed to include the use of a resting hand splint in Resident R307's plan of care. 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 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. Based on review of facility policy and clinical records, observations, and staff and resident interviews, it was determined that the facility failed to promote cleanliness and prevent the spread of infection regarding respiratory care equipment for two of four residents reviewed for respiratory care (Residents R8, R98,).Findings include:A facility policy entitled, Oxygen Administration dated 10/01/25, indicated that staff will change pre-filled humidification systems and tubing at least weekly, check concentrator filters for cleanliness and clean as needed with soap and water.Resident R8's clinical record revealed an admission date of 2/13/25, with diagnoses including chronic obstructive pulmonary disease (COPD- long-term, progressive lung disease that obstructs airflow, causing breathlessness, chronic cough, and sputum production), sudden respiratory failure, renal failure, pancytopenia (abnormally low levels of red blood cells, white blood cells, and platelets).A physician's order dated 11/16/25, to administer supplemental oxygen to Resident R8 at two liters/minute (LPM) via nasal canula (nc- nasal cannula is a thin, flexible tube that wraps around your head, typically hooking around your ears. On one end, it has two prongs that sit in your nose and deliver oxygen) as needed for shortness of breath.Resident R8's Treatment Administration Record (TAR) indicated he/she utilized the supplemental oxygen on 2/19/26, 2/21/26, 2/22/26, 3/05/26, and 3/10/26.Observations on 3/09/26, at 2:16 p.m. and 3/10/26, at 10:15 a.m. the oxygen concentrator (device that takes air from your surroundings, extracts oxygen and filters it into purified oxygen for you to breathe) external filter covered with copious amounts of gray fluffy substance, and the humidifier bottle was dated 12/09/25.Resident R98's clinical record revealed an admission date of 11/11/24, with diagnoses including COPD, heart disease, long-term respiratory failure, and seizures and a care plan dated 11/12/24, to administer oxygen therapy as needed to maintain oxygen saturation within parameters.Observation on 3/09/26, at 1:19 p.m. Resident R98 was lying in bed with his/her head elevated and the oxygen nasal cannula in his/her nose, and the external oxygen concentrator filter was covered with copious amounts of gray fluffy substance.Interview on 3/10/26, at 10:25 a.m. Registered Nurse (RN) Employee E34 confirmed that Resident R8's external concentrator filter was dirty and that the humidifier bottle was dated 12/09/25, and that the bottle should be removed and a new one provided when Resident R8 need to use his/her oxygen.Interview on 3/10/26, at 10:25 a.m. RN Employee E34 confirmed that Resident R98's external concentrator filter was dirty.Interview on 3/10/26, at 10:40 a.m. the Director of Nursing confirmed that the external concentrator filters should be cleaned, and the humidifier bottle should have been removed. 28 Pa. Code 211.5(f)(h) Clinical records28 Pa. Code 211.12(d)(1)(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 R79).Findings include:Review of facility policy Dialysis Care dated 10/1/25, indicated residents ordered dialysis therapy will be monitored and documentation will be maintained in the medical record. All residents receiving dialysis will be assessed before and after dialysis treatment and for compliance with their individualized plan of care. Review of the clinical record revealed Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/16/25, indicated diagnoses of high blood pressure, End Stage Renal Disease (ESRD - an inability of the kidneys to filter the blood), and anxiety. Review of a physician order dated 12/23/25, indicated leave for dialysis at 8:30 a.m. Monday, Wednesday, and Friday. Review of Resident R79s clinical record did not include complete communication forms for five days during the period of 2/1/26 through 3/9/26. The incomplete forms were on the following dates: 2/9/26, 2/16/26, 2/25/26, 2/27/26, and 3/4/26.During an interview on 3/10/26, at 10:02 a.m. Registered Nurse Employee E4 confirmed the above dates did not include complete dialysis communication forms and that the facility failed to provide consistent and complete communication with the dialysis center for Resident R79. 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **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 received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of five residents reviewed (Resident R153).Findings include: Review of the facility policy Trauma Informed Care last reviewed 10/1/25, indicated to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. Develop individualized care plans that address past trauma in collaboration with the residents and family, as appropriate. Review of the admission record indicated Resident R153 was admitted to the facility on [DATE]. Review of Resident R153's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/27/26, indicated the diagnosis of PTSD, depression and anxiety, Section I -indicated the diagnosis are active. Review of Resident R153's psychiatric evaluation dated 2/24/26, indicated symptoms of PTSD remain at baseline. Review of Resident R153's care plan dated 9/9/25, indicated:Focus: Resident has a mood problem related to (BLANK).Focus: Resident is at risk for alteration in mood related to (BLANK)The care plan failed to indicate that Resident R153 had PTSD and failed to identify any triggers and how to avoid them. During an interview on 3/12/26, at 12:10 p.m. Registered Nurse Employee E15 confirmed that the care plan failed to have a traumatic informed care plan addressing the PTSD or identifying potential triggers and prevention for re-traumatization and that the facility failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of PTSD for one of five residents (Resident R153). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of job description, clinical record review, facility documents, and staff interviews it was determined that the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to the use of mechanical lifts for two of seven employees (Nurse Aide (NA) Employee E26 and E27). Findings include: Review of the facility's NA Job Description indicated the NA will ensure a safe environment. Staff uses appropriate lifting devices to ensure resident and staff safety. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/26, indicated high blood pressure, depression, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Resident R55's physician orders dated 2/3/26, indicated that Resident R55 was to be transferred with a Hoyer lift, assist of two, no ambulation. Review of documentation provided by the facility identified as Nurse Aide (NA) Assignment Sheets on 3/10/26, indicated that resident R55 was transferred with Hoyer lift. Review of a written witness statement dated 3/2/26, from NA Employee E26 stated, At approximately 8:15 p.m., NA Employee E27 and I were preparing to transfer resident from her wheelchair to her bed via the Hoyer lift. As we were completing the transfer, resident slid out of the Hoyer and landed on her head. Nursing was immediately notified and resident was assessed and sent out to hospital for evaluation. Review of an interview conducted by facility dated 3/3/26, at 11:40 a.m. with NA Employee E27 stated, NA Employee E26 were transferring Resident R55, and I checked the Hoyer pad, there were no tears or anything. The Hoyer seemed to be working fine. I noticed the resident was starting to slide and I told NA Employee E27 to hurry so we could get her to the bed before she fell out but didn't make it in time. Review of an interview conducted by the facility dated 3/3/26, at 12:00 p.m. with NA Employee E26 stated, Transferring resident with NA Employee E27. I set up her room and hooked her up to the blue straps. We lifted her out of her chair and moved her toward her bed when she slid out bottom first. I did not notice her sliding before it happened. They Hoyer pad was still attached to the hoyer after she fell. During an interview on 3/10/26, at 10:05 a.m. the Director of Nursing stated, The NA's used the Hoyer pad that had the legs cut out on of during the Hoyer transfer and we replayed the scenario and did drawings and can not figure out what went wrong. During a review of facility provided documentation labeled Hoyer on 3/10/26, at 1:10 p.m. indicated that 46 residents utilize a Hoyer Lift and Hoyer pad for transfers. During a review of NA Employee E26 and E27 files on 3/11/26, failed to include a competency on how to utilize a Hoyer lift and the use of correct Hoyer pad and correct Hoyer pad size for each resident. During a review of facility provided documents on 3/11/26, labeled Mechanical Lift Competency Checklist revealed section (e) read the following and failed to include how to determine the proper Hoyer pad kind and size Position resident on the appropriate size sling and style as care plan and ADL book order (Kardex). During an interview on 3/13/26, at 9:32 a.m. Director of Nursing confirmed that the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to the use of mechanical lifts for two of seven employees (Nurse Aide (NA) Employee E26 and E27). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) for two of three residents (Resident R18, R104).Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the admission record indicated Resident R18 was admitted to the facility on [DATE]. Review of Resident R18's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/23/26, indicated the diagnoses of Crohn's Disease (chronic inflammatory bowel disease that affects the gastrointestinal tract, Peripheral Vascular Disease (narrowed arteries that reduce blood flow to the limbs) and unspecified intellectual disabilities. Resident R18's MDS assessment section C0200 BIMS score was a ten, indicating moderately impairment. Review of Resident R18s Binding Arbitration Agreement indicated that the resident signed the document on 7/16/25, with a severe cognitive impairment. Review of the admission record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/16/26, indicated the diagnoses of dementia (decline in cognitive function, affecting memory, thinking, behaviors and the ability to perform everyday activities), depression and anxiety. Resident R104's MDS assessment section C0200 BIMS score was a 0, indicating severe impairment. Review of Resident R104s Binding Arbitration Agreement indicated that the resident verbally agreed to the document on 7/29/25, with a severe cognitive impairment. During an interview with admission Director Employee E17 on 3/11/26 at 2:15 p.m. confirmed the facility failed to ensure resident rights to make informed decisions and choices in the residents' welfare by making certain residents understand the conditions of a binding arbitrtion agreement and failed to ensure the agreements is explained to the resident and his representative in a form and manner that he or she understands for two of three residents. 28 Pa. Code 201.21(b) admission Policy28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(b)(2) Management28 Pa. Code 201.29(a) Resident Rights

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **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 make certain that hospice documentation was maintained for two of four residents reviewed for hospice services (Resident R55 and R137). Findings include: Review of facility policy Special Needs dated 10/1/25, indicated the facility will ensure that residents receive proper treatment and care for the following special services: Hospice. All hospice services are provided under contractual arrangement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is on file in the facility. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/26, indicated high blood pressure, depression, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Resident R55's physician orders dated 3/29/25, revealed an order for hospice services. Review of Resident R55's hospice communication binder on 3/12/26, revealed a Hospice Certification and Plan of Care dated 11/24/25 – 1/22/26, a medication list dated 3/29/25, and a care plan dated 3/31/25. During an interview on 3/12/26, at 9:44 a.m. Licensed Practical Nurse (LPN) Employee E11 confirmed that Resident R55's clinical record lacked a current hospice plan of care, an updated medication list, and that the facility failed to ensure hospice documentation was maintained for Resident R55. Review of the clinical record indicated Resident R137 was admitted to the facility on [DATE]. Review of Resident R137's' MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety disorder and depression. Section O Special treatments: K1 indicated received hospice services. Review of Resident R137's current physician orders indicated admission to an outside vendor's Hospice Services on 2/16/26. Review of Resident R 137's hospice binder on 3/12/26, at 11:18 a.m. failed to include a current plan of care. During an interview completed on 3/12/26, at 11:18 a.m. Registered Nurse (RN) Employee E15 confirmed that Resident R137's hospice binder failed to include a current plan of care. During an interview on 3/12/26, at 2:30 p.m. Director of Nursing confirmed that Resident R55's hospice communication binder was not up to date and that the facility failed to make certain that hospice documentation was maintained for two of four residents reviewed for hospice services (Resident R55 and R137). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Rehab and Health	246 Friendship Circle Beaver, PA 15009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3) Nursing services Review of the clinical record indicated Resident R137 was admitted to the facility on [DATE]. Review of Resident R137's' MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety disorder and depression. Section O Special treatments: K1 indicated received hospice services. Review of Resident R137's current physician orders indicated admission to an outside vendor's Hospice Services on 2/16/26. Review of Resident R 137's hospice binder on 3/12/26, at 11:18 a.m. failed to include a current plan of care. During an interview completed on 3/12/26, at 11:18 a.m. Registered Nurse (RN) Employee E15 confirmed that Resident R137's hospice binder failed to include a current plan of care.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and staff interviews it was determined that the facility failed to make certain that equipment was in safe operating condition for one of three facility vehicles (vehicle one).Findings include: During an interview on [DATE], at 10:40 a.m. Resident R280 stated that one of the facility's vehicles used to transport residents to appointments, had an expired vehicle inspection sticker displayed. During an observation in the facility's parking lot on [DATE], at 2:58 p.m. facility vehicle number one was revealed to have an inspection sticker with an expiration date of [DATE]. During an interview on [DATE], at 8:33 a.m. Van Driver Employee E22 stated that the facility employs three Drivers who operate daily to provide transportation services for residents, and that three vehicles are used to complete these services. During an interview on [DATE], at 11:25 a.m. Van Driver Employee E23 confirmed that Vehicle number One had an expired inspection of [DATE]. During an interview on [DATE], at 11:30 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that equipment was in safe operating condition. 28 Pa Code: 201.14(a) Responsibility of licensee.

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Friendship Rehab and Health	246 Friendship Circle Beaver, PA 15009

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, personnel files and staff interview it was determined that the facility failed to ensure that one of four sampled Nurse Aides (NA) received a minimum of 12 hours of in-service education per year (NA Employee E7).Findings include: Review of facility policy Staff Development Program dated 10/1/25, indicated the facility will provide staff development and education to employees. Certified Nursing Assistants/Aides receive at least 12 hours of in-service per year. All employees receive in-service on mandatory in-services annually, with competency assessment included in the program. Annual training will include, at a minimum: Infection Prevention and Control, Fire Prevention and Safety, Accident Prevention, Disaster Preparedness, Confidentiality, Resident Psychosocial Needs, Restorative Nursing, Resident Rights, Privacy Rights and Dignity, Abuse Prevention and Reporting, Nutrition and Hydration, Hazardous Materials, and Ethical Code of Conduct. Review of NA Employee E7's personnel file indicated a date of hire on 11/18/13. Review of facility nurse aide training records revealed that NA Employee E7 did not receive 12 hours of in-service training from 1/1/25 through 12/31/25. The facility was unable to provide documented evidence that NA Employee E7 had received a minimum of 12 hours of in-service training yearly. During an interview on 3/11/26, at 1:58 p.m. Education Department Registered Nurse Employee E6 confirmed that the facility failed to ensure NA Employee E7 received the required 12 hours of yearly in-service training. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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Friendship Rehab and Health	246 Friendship Circle Beaver, PA 15009

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview it was determined that the facility failed to have required postings for the facility in areas that are accessible to all residents for Adult Protective Service information, complete contact information for State Agency, State Long-Term Care Ombudsman program, and Medicaid Fraud Unit, and failed to post a statement that residents may file a complaint with the State Agency posted at the facility.Findings include: During a tour of the facility and interview on 3/13/26, at 10:50 a.m. with the Nursing Home Administrator (NHA). posted information for residents was reviewed, and found to have lacked the following: no contact information for Adult Protective Services, no address or email for State Agency, no address for State Long-term Care Ombudsman, no address, or email for Medicaid Fraud unit, and no statement that residents may file a complaint with the State Agency. NHA confirmed the above findings, and that the facility failed to have required postings in areas that are accessible to all residents as required 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(b)(3) Management.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	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 observations, and staff interviews, it was determined that the facility failed to provide information on the grievance official throughout the facility as required.Findings include: During a tour of the facility and interview on 3/13/26, at 10:50 a.m. with the Nursing Home Administrator (NHA) Grievance Boxes were observed but failed to include the name of the Grievance Official, address, email, and phone number. NHA confirmed the above findings and that the facility failed to have information on the grievance official accessible to all residents as required. 28 Pa. Code 201.29(a) resident rights