STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395019	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, clinical records, observations, and staff interviews, it was determined the Facility failed to ensure residents were free from abuse and neglect by exhibiting a pattern of neglect of medically fragile residents. Residents R2, R25, R45, R47, and R100 who are totally dependent on staff for all of their needs were not provided incontinence care, ileostomy care, and lack of investigation of bruising with an unknown origin for the five of 29 residents reviewed. This failure to provide necessary goods and services to residents put residents at risk of serious health complications and resulted in an Immediate Jeopardy situation. Findings include: Review of facility policy and procedures titled Abuse dated April 9, 2024, revealed, it was the responsibility of the facility staff to ensure that each resident was free from abuse. Further review of the facility policy revealed each resident was to be protected from physical, mental, verbal, and sexual abuse. The policy further indicated each resident would be protected from neglect and harm while residing at the facility. The policy indicated abuse or neglect would not be tolerated at the facility. The policy indicated each resident was to be treated with respect and dignity. The policy indicated that all employees were to treat each resident in a manner that upholds a resident's sense of self-worth and individuality and does not perpetuate an environment of potentially abusive attitude toward residents. Additional review of same facility policy revealed the facility defines neglect as the failure of facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further review of policy revealed . residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. Review of undated facility policy and procedure titled Incontinence Care revealed it was the responsibility of the nursing staff to ensure that all residents who were incontinent of urine, feces or both, would be kept clean, receive timely, dignified and appropriate incontinence care aimed at maintaining skin integrity, promoting comfort and preserving dignity while preventing infection and complications. Review of facility policy titled Colostomy/ Ileostomy Care, (care by focusing on prevention of skin breakdown, infection control, proper appliance management, routine assessment, and consistent documentation to ensure safe and effective colostomy/ileostomy care), states the purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	matter. Review of Resident R2's quarterly Minimum Data Set assessment (MDS -federally mandated assessment tool), dated November 14, 2025, revealed the resident was admitted to the facility on [DATE]. Diagnoses include non-traumatic brain dysfunction, Stroke, seizure disorder, and respiratory failure. The MDS assessment also revealed that Resident R2 is ventilator dependent. Resident R2 has severely impaired hearing and vision, non-verbal, and rarely or never makes self understood or is able to understand others. Further review of Resident R2's MDS assessment revealed the resident was totally dependent for ADL care (assists of daily living) including turning. Review of Resident R2's care plan dated April 18, 2026, revealed the resident requires 1-2 person assistance for all ADL care. Review of facility document titled Grievance Summary dated September 18, 2025, revealed Resident R2 was found on (his/her) side with (his/her) face pressed into the mattress. The G-tube feeding valve had been ripped from the tube, causing tube feeding to spill onto the resident's clothing and linens. Red marks and bruising were noted across the left side of the body, and arm, with soiled linens containing urine and blood. A fresh wound dressing was noted on the sacrum post-care. The facility investigation documentation including video review, wound nurse interview, and nursing assistant interview revealed the incident was substantiated for neglect of care. Review of the wound nurse interview revealed the wound team did leave the resident as described. Further review of staff interview statements from staff indicated the wound care nurse had completed initial care and placed the resident on their side with clean dressings while instructing the nursing assistant (CNA) to finish care. According to staff statement, the CNA returned after rounds and found the resident left in the condition described. Interview with Director of Nursing on February 10, 2025, confirmed the substantiated investigative findings of neglect. Review of Resident R25's clinical record revealed medical diagnosis of overactive bladder, traumatic brain injury, bladder and bowel incontinence. Review of Resident R25's care plan revealed he was to be assessed for incontinence every 2 to 3 hours. Review of facility document titled Grievance Summary, dated November 20, 2025, by facility's grievance officer - Employee E14, revealed Resident R25 was found the morning of November 20, 2025, soaked in urine, it did not appear (Resident R25) had been changed all night. Further review of grievance summary revealed, per the camera review the resident was changed at 2:30 am and not again until day shift went in at 7:00 am. The resident (R25) received full care at 7:00 am and the 11-7 nurse aide (Employee E13), received a written education regarding rounding on residents. Additional review of the grievance summary revealed the facility determined the allegations of neglect to be unsubstantiated. Further review of document titled Grievance Summary revealed nurse aide, Employee E13, received education regarding two-hour rounding on November 25, 2025. Review of the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Employee E13's education document revealed the employee refused to sign the acknowledgment of education. Review of facility investigative documentation failed to reveal evidence of statements from nurse aides who were assigned to Resident R25; indicating a thorough investigation was not conducted by facility. Review of Resident R45's clinical record including a quarterly comprehensive assessment (MDS-assessment of care needs) dated November 5, 2025, revealed Resident R45 rarely understood others and had no spoken words. The assessment revealed Resident R45's cognitive abilities for daily decision making were severely impaired. The assessment identified Resident R45 as having functional limitations to range of motion of the upper and lower extremities. The assessment further revealed Resident R45 was totally dependent on two or more staff members to complete activities of daily living (personal and oral hygiene, bathing, toileting and dressing). The assessment revealed Resident R45 was totally dependent on two persons assist for functional abilities (rolling left to right, chair to bed and bed to chair transfers, tub/shower transfers). The section that indicated resident's bowel and bladder capabilities of Resident R45 revealed resident was always incontinent of bowel and bladder. Resident R45 was listed as having diagnoses of non-traumatic brain dysfunction, respiratory failure and seizure disorder. The nutritional approach indicated on the assessment was feeding tube. Observations conducted on February 9, 2026 of Resident R45 in bed lying supine, confirmed Resident R45 had functional limitations to the upper and lower extremities. Interview conducted on February 9, 2026, at 9:30 a.m., with the licensed nurse, Employee E19 confirmed Resident R45 was wearing a brief for incontinence of bowel and bladder. Interview conducted on February 10, 2026 at 1:00 p.m., with the Director of Therapy Services, Employee E16, confirmed Resident R45 required frequent monitoring by staff to evaluate medical, physical, and psychosocial needs; since the resident was unable to use the call bell or other adaptive equipment to let staff know that he/she was in need of care. Review of Resident R45's clinical record revealed a speech/language/swallowing evaluation dated February 11, 2026. The assessment revealed Resident R45 had cognitive communication deficit and was unable to use high/low technology equipment to enhance or communicate basic wants or needs to staff. Review of Resident R45's clinical record revealed a physician's order dated April 11, 2025, for nothing by mouth. The physician order dated April 11, 2025, indicated that nutritional sustenance was Jevity 1.2 (a fiber fortified therapeutic nutritional formula that provides complete nutrition) through enteral feeding at 85 cc per hour to be started at noon and completed at 6:00 a.m., over an 18-hour period daily. Resident R45 was also had a physician's order dated April 11, 2025, for 100 ml (milliliter) flush with normal saline solution at noon over 18 hours to be completed at 6:00 a.m., daily. Review of Resident R45's clinical record revealed a care plan dated June 1, 2021, indicating that Resident R45 was to be observed for incontinence care every two to three hours to maintain the resident's dignity and prevent skin breakdown. The care plan revealed the nursing staff were to wash, rinse, and dry perineum (diamond-shaped region at the base of the pelvis located between the thighs) after each incontinence episode and change resident's clothing and brief after each incontinence (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	episode. Review of Resident R45's Grievance Summary documentation dated November 21, 2025, filed on behalf of Resident R45 by a staff member Employee E17, Nursing Assistant, revealed that Employee E17 observed Resident R45 in bed, in the supine position, soaked in urine at 7:10 a.m. on the day shift (7a.m-3p.m.) on November 21, 2025. Review of this grievance report confirmed Resident R45's neglect allegations were substantiated as a result of the nursing assistant, Employee E18 failure to provide care during the eleven to seven-night shift (11p.m - 7a.m.) on November 21, 2025. Interview with the Director of Nursing, Employee E2, at 2:45 p.m., on February 10, 2026, confirmed Resident R45's neglect allegations were substantiated as a result of the nursing assistant, Employee E18 failure to provide care during the night shift (11p.m - 7a.m.) on November 21, 2025. The Director of Nursing also confirmed during this interview the Department was not notified of the alleged abuse or neglect for Resident R45. Additional review of the grievance report revealed that according to camera footage, the nursing assistant was only in the bedroom of Resident R45 at 1:30 a.m., during her assigned night shift. The nursing assistant, Employee E18 failed to provide the necessary services and care for Resident R45 who was incontinent of bowel and bladder and totally dependent on two staff persons for personal hygiene and toileting. Review of Employee E18's personnel file and interview with the Director Of Nursing, Employee E2, at 2:15 p.m., confirmed there was no documentation to indicate an action taken such as written education was provided by the licensed nurse related to prevention of neglect of toileting hygiene and incontinence care of Resident R45 that Employee E18 was responsible for during assigned tour of duty on the eleven to seven shift on November 21, 2025. Interview conducted with nursing assistant Employee E17, at 10:00 a.m., on February 10, 2026, confirmed Resident R45 was found heavily saturated in urine, smelling saturated with urine at 7:10 a.m., on November 21, 2025. Employee E17 revealed through observation, the resident did not receive bladder incontinence care at least every two hours, according to standards of practice for nursing care. Interview with the Director of Quality Experience, Employee E14 at 11:00 a.m., on February 10, 2026, confirmed the allegation of negligence for Resident R45 was documented as unsubstantiated on November 21, 2025. Review of Resident R47's clinical records revealed resident was admitted to the facility on [DATE], with diagnosis of cerebral infarction (stroke). Review of Resident R47's MDS (Minimum Data Set) dated November 12, 2025, revealed resident is dependent (helper does all the effort. Resident does none of the effort) for mobility and care. Review of information submitted to the Department by the facility dated August 15, 2025; revealed, Resident R47 was observed with a hematoma on the right posterior forearm, as well as a small bruise on the upper posterior arm. The resident is dependent on staff for all care needs, has bilateral arm contractures and a BIMS (Brief interview for Mental Status) score of 0 (indicating the resident is (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	severely cognitively impaired). Review of facility investigation, dated August 15, 2025, revealed injuries include right forearm-hematoma; right upper arm- right axilla bruise, purple superficial abrasion on right elbow, small yellowish green bruise posterior upper arm. Further review of facility investigation revealed Conclusion: the resident was observed with a hematoma on the right posterior forearm, as well as a small bruise on the right upper arm. A small bruise also noted on (his/her) right knee. The resident is dependent on staff for all care needs, has bilateral contractures, and a BIMS score of 0. (Resident) is also on anticoagulants which make (him/her) more susceptible to bruising. An investigation was completed and no perpetrator was identified. At this time, the investigation is closed with no substantiated findings. Further review of facility investigation revealed an interview conducted on August 15, 2025, with Employee E4, Licensed Practical Nurse, revealed called to shower room by CNA (Certified Nursing Assistant) to see hematoma on right forearm. Right forearm hematoma about 76 mm (millimeter(s)) egg shape noted and some ecchymosis areas around axilla area. Review of Employee E4, Licensed Practical Nurse's investigation statement, dated August 14, 2025, 7:00 p.m.-7:00 a.m. hematoma right posterior forearm about 76mm egg shape. Two approximately 16mm/21mm ecchymosis (discoloration of the skin resulting from bleeding underneath, typically caused by bruising) areas around axilla area. Small abrasion right elbow area around 10mm. Superficial scratch top of hematoma noted 1.5 inches. Review of Resident R47's progress note, dated August 17, 2025 at 4:29 p.m., revealed Resident is noted to have swollen, dark purple bruising to right forearm, anterior arm proximal to axilla (space below the shoulder through which vessels and nerves enter and leave the upper arm; a person's armpit) and light blue bruising on the right knee with a small healing abrasion on elbow and knee. Areas are not warm to touch, facial grimacing present when touched. Acetaminophen administered. Review of Resident R47's progress note, dated August 18, 2025, at 11:39 p.m., revealed Resident also being monitored for bruising which started on the inner aspect of the right upper arm, and since spread downward to the middle forearm accompanied by swelling. Review of Resident R47's progress note, dated August 19, 2025, at 11:41 p.m., indicated Ecchymosis observed on patient right forearm and right patella. Dark purple and red in coloration. Forearm is swollen but not warm to the touch. Face grimacing noted during gentle palpation. Review of Resident R47's progress note, dated August 20, 2025, at 3:21p.m., indicated Right forearm bruise continues- still raised and firm to touch- no pain expressed when palpated. Right knee bruise continues but with signs of improvement. Review of Resident R47's progress note, dated August 25, 2025, at 12:52 a.m., indicated Right forearm remains ecchymosis with edema noted. Review of Resident R47's progress note, dated August 31, 2025, at 3:55 p.m., revealed Ecchymosis observed on patient right forearm and right knee. Dark purple and red in coloration. Face grimacing noted during gentle palpation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R47's progress note, dated September 1, 2025 at 3:39 a.m., revealed bruising noted on resident's right forearm to elbow and right knee. Grimaces and moves in pain on palpation. Review of Resident R47's progress note, dated September 7, 2025, at 3:20 a.m., revealed mass still noted on posterior middle third of resident's right elbow; circular in shape, approximately 1.5 inches in diameter, raised approximately half an inch and skin tone darker compared to surrounding area. Review of Resident R47's progress note, dated September 20, 2025, revealed right forearm swollen with ecchymosis, right knee bruise intact. Review of Resident R47's progress note, dated September 23, 2025, at 2:17 p.m., revealed Hematoma of right forearm continues but is showing improvement- soft to the touch and appears to be fluid filled but the overall dimensions are receding, no s/s (signs / symptoms) of pain when palpated. Right knee has a small red/ purple bruise. Review of Resident R47's progress note, dated October 2, 2025, at 4:13p.m., revealed Hematoma to right forearm. Approximately 3 cm in diameter, 0.2 cm in height. Light purple and more yellow in color. No s/s of pain when palpated. Noted hematoma is soft to touch. Right knee with very light ecchymosis continuing. Review of Resident R47's progress note, dated October 7, 2025 at 1:42 p.m., stated Hematoma to right forearm is reddish and soft to touch- bruise to right knee is red and gradually resolving. Review of Resident R47's progress note, dated February 10, 2026, at 7:56 a.m., revealed resident continues with bruise to right arm. Observation of Resident R47 on February 10, 2026, at 12:35p.m., revealed resident right forearm with area of darkened pigmentation. Review of Resident R47's physician orders dated February 4, 2025, revealed bilateral padded side rails. Review of Resident R 47's physician order dated October 24, 2025, indicated observe whether padded side rails are in place. Review of Resident R47's Care plan date October 24, 2025, revealed Maintain padded side rails when in bed. Interview with Employee E5, Unit Manager on February 10, 2026, at 12:35 p.m. revealed that bed rails have always been in place for the resident's safety We got the padding after those bruises on (his/her) arms showed up likely from us rolling (resident) and (his/her) arms hitting the side rail. Interview with Employee E2, Director of Nursing on February 10, 2026 at 2:15 p.m., confirmed bed rails were in place during the time of incident. Additionally, Employee E2 confirmed, no care plan interventions or documentation related to the padded side rails were initiated prior to resident's injuries on August 15, 2025. Review of Resident R100's annual Minimum Data Set (MDS) assessment, dated January 27, 2026, revealed the resident entered the facility on February 12, 2025. Diagnoses include non-traumatic brain (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	disorder, Stroke, Depression, Anxiety, and respiratory failure. This resident is non-verbal and is sometimes able to understand and be understood. Resident is totally dependent on staff for all Activities of Daily Living (ADLs) and requires tube feeding for nutrition. Review of resident's BIMS (Brief Interview for Mental Status) score of 0, indication severe deficit. Review of Resident R100's grievance summary dated October 23, 2025, revealed approximately 3:30 PM on September 22, 2025, the resident was observed crying in the hallway. Investigation determined the resident had not been given incontinence care during previous shift, despite resident requesting assistance three times. Incontinence care was not provided until 3:45 PM. Further review of investigation documentation revealed a camera review conducted on September 22, 2025, revealed the assigned CNA, Employee E27, spent a significant portion of her shift—approximately 3.5 hours—at the nursing station rather than providing resident care. Further review of the investigative documentation including camera review revealed the resident was observed receiving morning care around 8:00 AM, then removed from his/her room at 9:00 AM and placed in the hallway. Resident R100 was returned to his/her room at 12:25 PM, then after care provided again placed in the hallway. Resident R100 was observed at 3:30 PM, crying in the hallway before receiving care at 3:45 p.m. The facility concluded the investigation and determined Resident R100's neglect of care had been substantiated. Employee E27, nursing assistant received education regarding proper care delivery. Based on the above findings, an Immediate Jeopardy situation was identified to the Nursing Home Administrator, Employee E1, on February 11, 2026, at 3:16 p.m. for failure to ensure residents were free from abuse and neglect related to a pattern of neglect for 5 residents. The failure to provide goods and services to residents that are necessary resulting in physical harm, and pain, and emotional distress. An immediate action template (document which included the information necessary to establish each of the key components of the immediate jeopardy) was provided to the Nursing Home Administered (NHA) on February 11, 2026, at 3:26 p.m. On February 11, 2026, at 7:09 p.m. the facility submitted an immediate plan of action that included the following: The residents will be assessed to determine their level of care status. Those identified will be reviewed to ensure incontinent care and ostomy care are provided as necessary. Identified residents R47, R25, R100, R45, and R26 in the template will have a skin assessment completed by February 12, 2026, and any identified areas will be treated as per physician recommendations. Any resident concerns will be reviewed by the Administrator and DON to determine if it falls under the definition of Abuse or Neglect for reporting and investigation. Staff will be in serviced on the abuse and neglect policy including reporting and proper investigation. The facility will be at 100% compliance by February 11, 2026, via text/email followed by an in person/ phone in-service prior to their next shift. New hires and agency will have the abuse policy reviewed prior to the start of their first shift. Resident concerns and incident reports will be reviewed weekly for 4 weeks then monthly by the administrator to ensure appropriate identification of suspected abuse/neglect allegations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These reports will be presented to the QAPI committee for monitoring and follow through The facility action plan was reviewed and interviews were conducted with staff to verify the implementation of the action plan. Staff confirmed education was provided and were able to verbalize the abuse and neglect processes and policies. Following verification of the immediate action plan the Immediate Jeopardy was lifted on February 12, 2026, at 2:48 p.m. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.29(a)(c) Resident rights 28 PA. Code 201.18(b)(1)(3)(4)(e)(1)(1)(3)(4) Management 28 PA. Code 211.10(a)(b)(c)(d) resident care policies 28 PA. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, review of CDC requirements, observations, and staff interviews, it was determined the facility failed to establish and maintain an effective Infection Prevention and Control Program including the utilization of appropriate personal protective equipment (PPE) during high-contact resident care and failed to adequately educate staff on evidence-based infection control practices for residents on four of four nursing units (NPRU Nursing Unit, NLC Nursing Unit, PLC1 Nursing Unit, and PLC2 Nursing Unit). This failure placed residents at high risk to health and was identified as an Immediate Jeopardy situation. Findings include: The facility's Infection Control Program policy titled Infection Control Program Overview undated, revealed that the program is designed to prevent, identify, investigate, and control infections and communicable diseases; provide ongoing surveillance; educate staff and residents on infection prevention practices; ensure adherence to standard and transmission-based precautions; and comply with state and federal regulations. The program further identifies the Infection Preventionist and Infection Prevention Committee as responsible for oversight, education, monitoring, reporting, and corrective actions. Review of the 2025 facility assessment, updated in October 2025 and reviewed in November 2025, indicates the purpose of the assessment is to determine the resources necessary to provide competent care to residents during day-to-day operations and emergencies. The facility resident profile reveals the facility is a specialized rehabilitation facility licensed for 153 beds. Under the current case-mix payment system, it is classified as a Special Rehabilitation Facility, reflecting a resident population in which more than 70% have neurological or neuromuscular diagnoses and multiple functional limitations. The facility provides care to residents with diagnoses that may include comatose status, cerebral palsy, multiple sclerosis, paraplegia, quadriplegia, traumatic brain injury, and ventilator dependence. The resident population primarily consists of individuals requiring long-term placement due to specialized needs, including ventilator-dependent, neurologically impaired, and spinal cord–injured residents. Review of facility policy presented during survey by the facility's Infection Preventionist, titled Isolation Requirements regarding isolation requirements revealed the facility identified and implemented three types of transmission-based precautions: Standard Precautions, Contact Precautions, and Airborne Precautions. However, the facility failed to acknowledge or implement Enhanced Barrier Precautions in accordance with current CDC guidance. The facility reported utilizing Standard Precautions for all residents, including those colonized with Vancomycin- Resistant Enterococcus (VRE-type of bacteria that has become resistant to the antibiotic vancomycin), Methicillin- Resistant Staphylococcus aureus (MRSA-a type of bacteria that has become resistant to many antibiotics),or Extended Spectrum Beta-Lactamase or ESBL-producing organisms(enzymes made by certain bacteria that make them resistant when the resident was not receiving active treatment. Contact Precautions were reportedly implemented for residents receiving active treatment for MRSA, VRE, Clostridioides difficile (C. diff), ESBL-producing organisms, Carbapenem-resistant Enterobacterales (CRE--gram negative bacteria that are resistant to many bacteria)), Klebsiella pneumoniae carbapenemase (KPC-an enzyme produced by certain bacteria, when bacteria produces KPC, they become highly resistant to many antibiotics), (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Carbapenem-resistant A. baumannii (CRAB-highly drug resistant bacteria that can cause serious infections) or other carbapenemase-producing organisms (infections that do not respond to antibiotics) regardless of treatment status, as well as for residents with conjunctivitis, highly contagious skin conditions, or Candida auris. Airborne Precautions were identified for residents diagnosed with influenza, COVID-19, RSV, varicella (chickenpox), herpes zoster (shingles), and pertussis, with instructions that residents wear well-fitting source control when outside of their rooms. Review of the Center for Disease Control and Prevention guidance Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) April 2, 2024 (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html?utm_source=chatgpt.com) revealed that the Centers for Disease Control and Prevention (CDC) updated its guidance on July 12, 2022, regarding the implementation of Personal Protective Equipment (PPE) use in nursing homes to prevent the spread of Multidrug-Resistant Organisms (MDROs). The update added further rationale supporting the use of Enhanced Barrier Precautions (EBP), citing the high prevalence of MDRO colonization in nursing home residents, with studies indicating that more than 50% of residents may be colonized. The CDC expanded the population for whom EBP applies to include any resident with a wound or indwelling medical device, regardless of MDRO colonization or infection status, and broadened the list of MDROs for which EBP is recommended. The guidance also clarified that, in most situations, EBP should be continued for the duration of a resident's admission rather than being time-limited. The CDC emphasizes that MDRO transmission is common in skilled nursing facilities and contributes to significant resident morbidity, mortality, outbreak potential, limited treatment options, and increased healthcare costs. Enhanced Barrier Precautions are an infection prevention intervention designed to reduce transmission of resistant organisms through the targeted use of gowns and gloves during high-contact resident care activities. EBP are indicated, when Contact Precautions do not otherwise apply, for residents with wounds or indwelling medical devices and for residents infected or colonized with an MDRO. Effective implementation requires appropriate staff education and training on proper PPE use, as well as ensuring the availability of gowns, gloves, and hand hygiene supplies at the point of care. Standard Precautions continue to apply to the care of all residents at all times, regardless of infection or colonization status. The CDC developed Enhanced Barrier Precautions in recognition that traditional Contact Precautions, which require gown and glove use for all room entry, private room placement or cohorting, and room restriction, can be difficult to sustain in nursing homes and may negatively impact resident quality of life. Because MDRO colonization can persist for months and contribute to silent transmission, focusing solely on residents with active infection does not adequately address transmission risk. Enhanced Barrier Precautions provide a more targeted and sustainable approach by requiring gown and glove use during high-contact care activities—such as bathing, dressing, transferring, toileting, wound care, device care, and changing linens—without requiring routine room restriction or private room placement. Observations conducted across four units on February 8, 2026, revealed that Enhanced Barrier Precautions were not implemented or observed. The only precautions observed were random doors displaying Contact Precautions signage with corresponding PPE requirements, and no additional precautions were observed beyond Standard, Contact, or Airborne Precautions. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R1's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of traumatic brain injury, gastrostomy (artificial opening in stomach for nutritional support or gastric decompression), tracheostomy (tube inserted into opening through the neck into the trachea). Review of Resident R1's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R1's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R1's room on February 8, 2026, approximately 10:15 a.m. revealed no sign for enhanced barrier precautions. Review of Resident R5's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of Parkinson's (movement disorder of the nervous system), tracheostomy, gastrostomy. Review of Resident R5's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R5's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R5's room on February 8, 2026, approximately 10:15 a.m. revealed no sign for enhanced barrier precautions. Review of Resident R7's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of Guillain Barre Syndrome (rare neurological disorder in which a person's immune system mistakenly attacks part of nervous system), tracheostomy, gastrostomy. Review of Resident R7's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R7's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R7's room on February 8, 2026, approximately 10:15 a.m. revealed no sign for enhanced barrier precautions. Review of R45's quarterly Minimum Data Set (MDS) dated [DATE], revealed resident was admitted the facility on May 21, 2012, and requires tube feeding. Observation of Nursing Assistant employee E8 providing care on February 8, 2025, at 10:50 a.m. revealed that the employee was only wearing gloves (standard precautions). Review of Resident 55's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was admitted to the facility on [DATE], and requires tube feeding. Observation on February 8, 2026, revealed Licensed Nurse E9 was observed administering medications via a feeding tube. During the procedure, the feeding tube became clogged, and the nurse attempted to dislodge it while wearing only wearing gloves (standard precautions). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R58's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of chronic respiratory failure, tracheostomy, gastrostomy. Review of Resident R58's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R58's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R58's room on February 8, 2026, approximately 10:15 a.m. revealed no sign for enhanced barrier precautions. Observation on February 8, 2026, at 12:53 p.m. revealed Employee E5, Respiratory Therapist preforming suction of tracheostomy on Resident R58, Employee E5 was observed wearing gloves but not wearing a gown during care. Review of Resident R81's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of anoxic brain injury, tracheostomy, gastrostomy. Review of Resident R81's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R81's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R81's room on February 8, 2026, at approximately 10:15 a.m., revealed no sign for enhanced barrier precautions. Review of Resident R83's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of stroke, tracheostomy, gastrostomy. Review of Resident R83's clinical record revealed no physician order for enhanced barrier precautions. Review of Resident R83's clinical record revealed no care plan in place for enhanced barrier precautions. Observation of Resident R83's room on February 8, 2026, approximately 10:15 a.m. revealed no sign for enhanced barrier precautions. Interview with Employee E2, Director of Nursing on 2/9/2026 at 3:00 p.m., confirmed Resident R1, R5, R7, R58, R81, and R83 should be on Enhanced Barrier Precautions. Review of Resident R99's admission MDS (Minimum Data Set, federally mandated assessment tool for all residents) dated January 13, 2026, revealed the resident entered the facility on January 7, 2026, and requires a feeding tube and a tracheostomy. Observation on February 8, 2026, at approximately 9:50 a.m., of Nursing Assistant E6 revealed the nursing assistant was observed providing care to Resident R99, including cleaning and changing, without EBP. Review of Resident 132's Annual MDS (Minimum Data Set) dated December 12, 2025, revealed the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	identified the proper enhanced barrier precautions will be implemented This facility will identify those residents with an indicator at the entrance of the room PPE (personal protective equipment) will be placed in accessible areas on the units Staff education on when PPE should be utilized will be ongoing The infection control policy will be reviewed and revised as necessary to ensure it is in line with acceptable standards [NAME] Health Department was in the facility on February 10 2026 to provide in servicing to the director of nursing, infection preventionist won't enhance barrier precautions The infection preventionist will be serviced as well as all staff within the facility on the infection control and policy and protocols including enhanced barrier precautions. The facility will be at 100 percent compliance by February 11, 2026, via text or email followed by an in-person or phone in-service prior to their next shift. Infection control rounds will be completed randomly by the don or director of nursing or designee weekly for four weeks then monthly thereafter Results of rounds will be presented to QAPI committee for monitoring and follow through. Review of the employee list, notifications, and confirmation of the policy on enhanced barrier precautions and PPE was conducted. Interviews with randomly selected employees confirmed they have been educated on enhanced barrier precautions, the proper use of PPE, and the identification of residents requiring enhanced barrier precautions. An interview with the infection preventionist revealed a thorough understanding of the enhanced barrier precautions policy, including its implementation and proper use of PPE. Review of the facility policy confirmed that enhanced barrier precautions are included and that all staff will receive appropriate education on the policy. Verification of the implementation of the Immediate Action Plan and review of staff education documentation indicated that the immediate jeopardy was lifted on February 12, 2026, at 2:48 p.m. 28 Pa. Code 201.20 (a)(6)(b)(d) Staff Development 28 Pa. Code 201.14 (a)Responsibility of Licensee 28 Pa. Code 211.1© Reportable Diseases 211.10 (d)Resident Care Policies 2122.12(b)(c)(d)(5) Nursing Services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on clinical record and facility documented grievance summary reviews, interviews with staff and residents and review of facility policy and procedures, it was determined that the facility failed to ensure that residents were able to identify the grievance officer, each resident was given a copy of the grievance policy and ensure that the grievance policy was in place to process grievances promptly, notified each resident of the progress and resolution of their concerns for thirteen of fifteen residents reviewed. (Residents R120, R41, R27, R17, R44, R46, R53, R72, R90, R128, R141, R59 and R109) Findings include: A review of the undated facility policy titled Resident Concern Policy revealed that the facility staff were responsible for providing residents with the best possible care. The policy also indicated that residents and family members could report a concern. The policy said that the concern would be investigated by facility staff in a timely manner. The policy indicated that a plan of correction would be implemented to address the problem, by attending to each resident's individual preferences and needs. A group meeting was held with alert and oriented Residents R120, R41, R27, R17, R44, R46, R53, R72, R90, R128, R141, R59 and R109 at 10:30 a.m., on February 9, 2026, the residents who attended the meeting reported that they were not given a copy of the grievance policy. The residents attending the meeting also reported that they were unable to identify the grievance official by sight or by name. The residents reported that they did not know the business address and phone number of this person. The residents said that the name or contact information of the grievance officer was not posted in prominent locations throughout the facility. Interview with the Administrator, Employee E1, at 2:10 p.m., on February 9, 2026, confirmed that the name and business contact information of the staff member that was responsible for preforming the grievance officers' duties within the facility was not visually readily accessible and posted in prominent locations throughout the facility. A review of the documented grievance summary dated November 9, 2025, revealed that Resident R120 had a care concern about treatment that was unfurnished by the nursing staff on November 9, 2025, and concern was also with the attitude of the nursing staff member responsible for providing care on November 9, 2025. Resident R120 reported that (he/she) did not receive assistance with morning care and activities of daily living until 12:30 p.m., on November 9, 2025. Resident R120 said that (he/she) missed coffee hour and that was upsetting. The resident said that (he/she) looks forward to that activity in the dining area. Clinical record review for Resident R120 revealed a psychiatrist progress note dated February 9, 2026, that indicated that this resident was oriented to time, place and person. The psychiatrist indicated that Resident R120 had fair judgement abilities. Clinical record review revealed a care plan that indicated that Resident R120 was an early riser and liked to attended coffee hour at 9:30 a.m., daily. Interview with the recreational activity's coordinator, Employee E21, at 2:30 p.m., on February 9, 2026, coffee hour was an activity that Resident R120 enjoyed attended regularly. Clinical record review for Resident R120 revealed a quarterly comprehensive assessment (MDS-an assessment of care needs) dated November 24, 2025, that indicated this resident usually understands and was understood with oral communication with staff. The assessment indicated that Resident R120 had functional limitations of the lower extremities and with range of motion that required substantial assistance to be provided by staff. The assessment indicated that this resident required substantial assistance with dressing, personal hygiene, chair to bed/bed to chair transfers. Resident R120 was non-ambulatory and used a wheelchair for mobility. The assessment also said that Resident R120 was frequently incontinent of bowel and bladder. A review of the documented grievance summary of events for November 9, 2025, revealed that the concern for lack of necessary and timely care for Resident R120 was not verified according to the conclusion documented on the grievance summary form; however, the rationale for this concern was verified, according to the statement of Resident R120 and the statement of nursing assistant, Employee E25, neglected to provide timely assistance with dressing, personal hygiene, toileting and (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers for Resident R120 on November 9, 2025. A review of the documented grievance summary of events dated January 8, 2026, revealed that a family member told staff that she was concerned for Resident R41. The family member indicated that Resident R41 was had not had a shower or bath. The family member reported that Resident R41 smells of body odor and feces and urine. Clinical record review for Resident R41 revealed a quarterly comprehensive assessment (MDS-assessment of care needs) dated January 5, 2026, that indicated this resident was cognitively intact and had functional impairment of the upper and lower extremities. The assessment said that Resident R41 was totally dependent for personal hygiene, bathing toileting eating, chair to bed/bed to chair transfers. Resident R120 was assessed as being incontinent of bowel and bladder. The assessments indicated that the resident was 77 inches tall. The documented grievance summary dated January 8, 2026, revealed that after interview with Resident R41, nursing staff and the family member it was concluded that the concern was unsubstantiated., however the rational provided for the response to this concern was verified. The grievance that was filed on January 8, 2026, was verified with Resident R41, who was alert and oriented and reporting that (he/she) had been refusing care and bathing. The nursing staff responsible for providing care and bathing for this resident indicated that Resident R41 was not provided care and bathing on January 8, 2026. There was no documentation to indicate that the facility made prompt efforts to investigate and reasonably resolve this grievance for Resident R41 and his concerned family member. Interview with Resident R41's family member at 10:00 a.m., on February 10, 2026, revealed that it was obvious that the resident did not receive care and bathing. The family member reported that Resident R41's body and room smelled of urine and feces on January 8, 2026. Interview with Resident R41 at 11:00 a.m., on February 10, 2026, revealed that the reason for (his/her) refusal of care and bathing was that (he/she) did not want foreign nursing assistants taking care of (him/her) could not understand them and their statue was small. Resident R41 reported (he/she) is a tall individual and did not want them to drop (him/her). Resident R41 also reported that he would prefer a male nursing staff member to provide incontinent care and bathing for safety reasons. Resident R41 reported that he has a preference for a certain variety of soap for bathing. The resident reported that the facility does not use the brand preferred. Interview with the licensed practical nurse, Employee E19, at 11:30 a.m., on February 10, 2026, confirmed that Resident R41 required a mechanical lift for transfers from bed to chair/chair to bed. The nurse also confirmed that this resident required assistance of two or more for bowel and bladder incontinence care. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.29(a) Resident rights 28 PA. Code 211.10(c)Resident care policies 28 PA. Code 211.12(c)(d)(1) Nursing services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility provided documentation, review of facility policy, review of clinical records and interview with staff and residents, it was determined that facility did not ensure allegations were properly investigated to prevent and correct alleged violations for two of 29 residents reviewed (Resident R83 and R100)Findings include:Review of facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated revised September 2022, revealed, The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. Investigation of abuse: when an incident or suspected incident of abuse is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: 1. Who was involved, 2. Resident statements; for non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview residents first. If unable, observe resident and complete an evaluation of resident behavior, affect and response to interaction, and document findings. 3. Resident's roommate statements (If applicable) 4. Involved staff and witness statements of events 5. A description of the resident's behavior and environment at the time of the incident. 6. Injuries present including a resident assessment 7. Observation of resident and staff behaviors during investigation 8. Environmental considerations. All staff must cooperate during the investigation to assure the resident is fully protected. Review of facility grievances revealed care concern related to Resident 83, dated November 6, 2025, stated A dayshift CNA (nurse aide) is concerned about the care provided over night to this resident. He was heavily wet when he came in this morning. Summary of findings stated It was found that the 11-7 CNA started her rounds at 0500 (5:00 a.m.) with the residents room. Care was provided to both residents in the room. She then continued her last rounds. The 7-3 CNA did not enter the room until 07:50am. That is just over two hours since the previous rounds were completed. This is plenty of time for the resident to have urinated after his last change. Review of facility investigation revealed no statements were taken from any residents or staff members. Further review revealed no skin assessment completed. Interview with Employee E14, Grievance officer, on February 10, 2026,at approximately 2:00 p.m. confirmed no further information available regarding this referenced incident. Review of Resident R100's Annual Minimum Data Set (MDS), dated [DATE], revealed the resident was admitted to the facility on [DATE], with diagnoses including non-traumatic brain disorder, cerebrovascular accident (stroke), depression, anxiety, and respiratory failure. The MDS indicated the resident is non-verbal, is sometimes able to understand and be understood, is totally dependent on staff for all Activities of Daily Living (ADLs), and requires tube feeding for nutrition. Review of a grievance/incident report for Resident R100 revealed that at approximately 3:30 p.m. on September 22, 2026, the resident was observed crying in the hallway. The facility's investigation included review of camera footage, which showed the resident requesting assistance to be changed on three occasions. The investigation determined the resident had not been provided incontinence care during previous rounds. Care was not provided until approximately 3:45 p.m. The camera review further indicated that the assigned CNA (nurse aide) spent an excessive portion of the shift-approximately 3.5 hours-at the nurse's station rather than providing resident care. According to the report, the resident received morning care at approximately 8:00 a.m., was removed from the room at 9:00 a.m. and placed in the hallway, returned to the room at 12:25 p.m., and later placed back in the hallway. At approximately 3:30 p.m., Resident R100 was again observed crying in the hallway prior to receiving care. Review of the facility's investigative documentation revealed the investigation relied solely on camera footage. The investigation did not include interviews with the assigned nurse aide, other staff working the shift, residents assigned to the assigned nurse aide. There was no documented evidence that a skin assessment of Resident R100 was completed to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determine potential negative outcomes. The facility concluded the allegation was substantiated and documented that the nurse aide received education regarding proper care delivery. However, the investigation lacked evidence of a comprehensive review to determine the scope of the issue or whether other residents assigned to the nurse aide were affected. 28 Pa Code 201.14(a) Responsibility of licensee28 Pa Code 201.18(b)(1) Management28 Pa Code 211.10(d) Resident care policies28 Pa Code 211.12(c) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 policy, review of clinical records, and interview with staff and residents, it was determined that facility did not ensure comprehensive care plans were developed and implemented regarding behaviors, refusals, bathing, activities, and toileting for three of 29 residents reviewed (Resident R131, R26 and R84). Review of facility policy 'Care Plans -Comprehensive,' unknown revision date, states that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Further review of policy indicates that each resident's comprehensive care plan has been designed to: a. incorporate identified problem areas; b. incorporate risk factors associated with identified problems; e. identify the professional services that are responsible for each element of care; f. aid in preventing or reducing declines in the resident's functional status and/or functional levels. Review of Resident R26 clinical records, revealed Resident R26 was admitted to the facility on [DATE], with diagnosis of altered mental status, acute respiratory failure, ileostomy. Review of Resident R26's MDS (Minimum Data Set) assessment revealed resident has BIMS (Brief interview for mental status) of 15, indicating cognitively intact. Review of facility grievance form regarding Resident R26, dated December 9, 2025, revealed the morning shift was concerned when they came in and found that the resident's colostomy bag was completely full and resident appeared to have received a bed bath. Further review of document revealed under Summary of Investigation an outcome of substantiated for neglect. Review of Resident R26's care plan, revised October 16, 2025, indicated Resident has a history of refusing care in the following areas: treatment administration. Interventions include: If refusing or resisting try again later. Notify physician and Responsible party of resident refusals of care and document: include attempts to re-educate. Document each instance of refusal and reason provided. Review of Resident R26's physician orders, dated October 2, 2025, Empty colostomy bag, every night shift. Review of Resident R26's clinical record revealed no documented evidence that resident refused care prior to incident. Review of facility investigation documents revealed interview with Employee E3, Licensed Practical Nurse stating [Resident R26] was refusing care. Employee E26, Nursing Assistant went in and I went in to try to convince [resident], (he/she) still told us no. I am sorry I should have written a note. We went in so many times and (he/she) told us no. Review of Resident R26's TAR (Treatment Administration Record) revealed that on December 9, 2025, ileostomy care was documented as being provided to the resident during shift (7p.m- 7a.m.) Interview with Employee E2, Director of Nursing on February 11, 2026, at 1:15 p.m. confirmed findings (continued on next page)

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Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that care was signed out, despite statement from nurse that care was not provided. Further interview confirmed no physician or responsible party notifications or educations related to refusals documented for resident. Review of Resident R131's clinical record revealed medical diagnosis of traumatic brain injury, reduced mobility, muscle weakness, aphasia (language disorder impairing ability to speak, understand, read, and write while often leaving intelligence intact.) Review of facility provided grievance report, completed on October 15, 2025, states (Resident R131) also does exhibit behaviors such as throwing items around the room. Review of R131's clinical records revealed progress note dated December 23, 2025 at midnight, stating that at times (he/she) can be heard yelling, and remains on Q (every) 30 minute checks. Review of progress notes dated December 19, 2025 at 4:40 pm, states (Resident R131) continue with regular behaviors of playing with bed remote, yelling, while in sitting in wheel chair pushing and pulling self in room . Review of R131's progress notes, dated January 1, 2026 at 1:24 pm, states (Resident R131) continues on 30 minute safety checks. No behavior issues noted this shift other than yelling for no reason other than to [NAME] attention. If you went into room and conversed with (him/her) (he/she) is quiet. Further review of Resident R131's clinical record revealed progress notes dated January 20, 2026 at midnight, stating (he/she) can be heard yelling at times from (his/her) room. Further review of progress note dated January 27, 2026 at 10:59 am, states Resident R131 had some yelling out this am. When someone goes into (his/her) room (he/she) quiets down and does not yell. Further review of progress notes dated February 1, 2026, at 3:27 pm, states Resident R131 had no behavior issues other than yelling out for someone to come into the room to talk with the resident. Further review of progress notes dated February 7, 2026, at 8:36 am and at 8:39 am indicated Resident R131 was hitting (himself/herself) and yelling. Review of Resident R131's care plan revealed no goals or interventions related to throwing items, and calling/yelling. Review of Resident R84's clinical record revealed medical diagnosis of schizophrenia (mental disease characterized by loss of reality contact), anxiety disorder, restlessness and agitation, cognitive communication disorder. Review of R84's clinical record revealed progress notes dated November 7, 2025 at 7:18 pm, stating that the resident attempted to remove ventilator on multiple occasions, further stating that the resident wants to die. Resident observed to be alert but agitated and noncompliant with care. Refusing nursing interventions and assistance. Resident expressed suicidal ideation and demonstrating self-harming behavior by removing the ventilator. Appears anxious and distressed. Further review of Resident R84's clinical record revealed progress notes dated November 9, 2025 at 8:28 am, indicating (Resident R84) had multiple episodes of screaming and making attempts to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disconnect vent. Bilateral hand mitts were applied to prevent self harm as resident continues to have suicidal thoughts. Needs met and resident denies any pain and stated that she doesn't know why (she/he) is yelling at that (she/he) do not want to live anymore. PRN (as needed) Ativan was administered at this time w/ positive effect. Report given to oncoming nurse regarding behaviors. All safety measures in place. Review of psychology note dated November 14, 2025, indicates resident was to be provided with a radio as alternative to watching TV. Review of R84's care plan revealed no evidence of goals or interventions related to address Resident R84's behaviors. 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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, review of policy, review of facility provided documentation and review of clinical record, it was determined that facility did not ensure resident safety related to shower thermometers in three of four showers and for the emergency pull system for one of three reviewed and did not ensure to provide adequate supervision to avoid accident during hygiene care (Resident R2)Review of facility policy ?Abuse' policy, reviewed on January 21, 2020, defines neglect as failure of facility , its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of Resident R2's clinical record revealed medical diagnosis of anoxic brain damage, contracture of bilateral wrists and hands, muscle weakness, reduced mobility. Review of R2's clinical record revealed progress notes dated August 4, 2025, at 12:50 am, indicating multiple scattered skin tears are observed to the lower face, secondary to trauma/injury due to a shaving razor. Review of facility provided grievance report, completed on August 4, 2025, indicates that on August 2nd, 2025, nurse aide, employee E15, shaved R2 and caused several cuts on his upper lip and chin.Review of skin observation assessment completed on August 3, 2025, at 7:16 pm indicates R2 was observed to have razor cuts on the lip and chin.28 Pa Code 211.12 (c) (d)(1)(3)(5) nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of policy, review of facility provided documentation and interview with staff, it was determined that facility failed to ensure timely incontinence care for two of 29 residents reviewed (Resident R25, and R131)Review of facility policy ?Incontinence Care,' indicates that it is its purpose to ensure that all residents who are incontinent of urine, feces, or both are kept clean, receive timely, dignified, and appropriate incontinence care aimed at maintaining skin integrity, promoting comfort, and preserving resident dignity while preventing infection and complications. Observations on morning of Sunday, February 8, 2026, in room [ROOM NUMBER]-D, Resident R131 was sitting in wheelchair with strong urine odor present in the room and bed linens stripped off of bed. Review of Resident R25's clinical record revealed medical diagnosis of overactive bladder, traumatic brain injury, bladder and bowel incontinence. Review of facility provided grievance report, completed on November 20, 2025, by facility's grievance officer - Employee E14, revealed that Resident R25 was found on morning of November 20, 2025 soaked in urine, it did not appear (he/she) had been changed all night. Further review of grievance report revealed that per the camera review the resident was changed at 2:30 am and not again until day shift went in at 7:00 am. The resident (R25) received full care at 7:00 am and the 11-7 nurse aide (Employee E13), received a written education regarding rounding on residents. Further review of facility provided documentation revealed that nurse aide, Employee E13, received education regarding two-hour rounding on November 25, 2025; further review of this training provided by assistant director of nursing, revealed employee refused to sign acknowledgment of education received. 28 PA. Code 211.10((d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations of the dietary services for the residents, meal tray delivery by the nursing staff and food and nutrition department staff, reviews of dietary policies and procedures, interviews with residents and staff and reviews of meal tray evaluations, it was determined that the facility failed to ensure that foods being served to the residents were palatable and appetizing temperatures for one of three nursing units reviewed. (200 nursing unit) Findings include:A review of the undated dietary policy and procedure titled serving of food revealed that it was the responsibility of the food and nutrition services department to prepare and serve food in a manner to prevent food borne illness and meet the individual needs of each resident. The policy indicated that hot entree, starches and vegetables were to be served to the residents at or above 120 degrees Fahrenheit. A group meeting was held with alert and oriented residents at 10:30 a.m., on February 9, 2026. The residents reported being unsatisfied with the taste and temperature of the foods and beverages that were being served for meals (breakfast, lunch and dinner) from the dietary department. Observations of the meal noon meal service on February 9, 2026, for the residents on the 200-nursing unit on February 9, 2026, revealed that the preplanned menu for a regular diet called for knockwurst on a roll, with pierogies, and California mixed vegetables as the hot food entree. Observations of the foods that were actually served were knockwurst on a roll, three small pierogies placed on top of mashed potatoes and steamed onions and peppers. California mixed vegetables are traditionally steamed or roasted cauliflower, broccoli and carrots. Mashed potatoes were not on the preplanned menu. The hot foods tested at point of service for the residents were 120 degrees Fahrenheit. The foods (tiny pierogies) tasted dry and over-cooked. The pierogies were difficult to chew. Interview with the Director of Dietary Services, Employee E22 about the test tray evaluation revealed that there were not enough pierogies; so, the kitchen staff substituted mashed potatoes. There were also not enough California mixed vegetables, so the kitchen staff substituted other vegetables. The residents were not notified of the substituted food items on the menu for the day (February 9, 2026). A review of the test trays that were completed by the Director of Dietary Services, Employee E22, on November 5, 2025, and January 14, 2026, revealed that the hot entree was served at 130 degrees Fahrenheit on November 5, 2025, for the noon meal. On January 14, 2026, the hot entree was served at 170 degrees Fahrenheit for dinner. Observations of the air temperature inside the main kitchen on February 8 and 9, 2026, revealed that the air temperature was registering 50 to 64 degrees Fahrenheit. These temperatures were taken with the Maintenance Director, Employee E24 at 11:15 a.m., on February 8 and 9, 2026. The kitchen was extremely cold for the dietary staff to work and perform their tasks. Observations of the meal tray delivery system from the main kitchen to the nursing units revealed that dietary staff were using open slotted carts to deliver the foods and beverages for breakfast lunch and dinner. The dietary staff were observations using a heating system and industrial sized piece of dietary equipment (pellet/plate warmer) to hold foods hot while transporting them to the nursing units. The manufacturers specifications indicated that the dietary equipment could heat pellets and plates from 180 degrees Fahrenheit to 250 degrees Fahrenheit. Observations of the dietary equipment on February 8 and 9 2026 revealed that the temperature was registering at 165 degrees Fahrenheit. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies28 PA. Code 201.14(a) Responsibility of licensee

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on the review of clinical records, job descriptions, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to make certain that proper procedures were followed in the facility related to failure to ensure residents are free from abuse and neglect relating to bruising of unknown origin, emptying ileostomy bag, wound care and incontinent care for six of 29 residents reviewed. (Resident R2, R25, R26, R47, R45, R100). Further determined, that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to make certain that proper procedures were followed in the facility related to establishing and maintaining an effective Infection Prevention and Control Program including the utilization of appropriate personal protective equipment (PPE) during high-contact resident care and failed to adequately educate staff on evidence-based infection control practices for residents on four of four nursing units (NPRU Nursing Unit, NLC Nursing Unit,, PLC1 Nursing Unit,, and PLC2 Nursing Unit). This failure resulted in two Immediate Jeopardy situations.Findings Include:Review of the job description for the Nursing Home Administrator (NHA) revealed that The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. Review resident complaints and grievances and make written reports of action taken. Discuss with resident and family as appropriate. Ensure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Ensure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan.Review of the job description for the Director of Nursing (DON) revealed that The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Ensure that all personnel performing tasks that involve potential exposure to blood/body fluids participate in appropriate in-service training programs prior to performing such tasks. Ensure that adequate supplies of personal protective equipment are on hand and are readily available to personnel who perform procedures that involve exposure to blood or body fluids. Monitor nursing service personnel to ensure that they are following established safety regulations in the use of equipment and supplies. Review complaints and grievances made by the residents and make a written/oral report to the Administrator indicating what action(s) were taken to resolve the complaint or grievance. Follow facility's established procedures.The facility's Infection Control Program policy titled Infection Control Program Overview undated, indicated that the program is designed to prevent, identify, investigate, and control infections and communicable diseases; provide ongoing surveillance; educate staff and residents on infection prevention practices; ensure adherence to standard and transmission-based precautions; and comply with state and federal regulations. The program further identifies the Infection Preventionist and Infection Prevention Committee as responsible for oversight, education, monitoring, reporting, and corrective actions.Review of facility policy presented during survey by the facility's Infection Preventionist, titled Isolation Requirements regarding isolation requirements revealed the facility identified and implemented three types of transmission-based precautions: Standard Precautions, Contact Precautions, and Airborne Precautions. However, the facility failed to acknowledge or implement Enhanced Barrier Precautions in accordance with current CDC guidance.Observations conducted across four units on February 8, 2026, revealed that Enhanced Barrier Precautions were not implemented or observed. The only precautions observed were random (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doors displaying Contact Precautions signage with corresponding PPE requirements, and no additional precautions were observed beyond Standard, Contact, or Airborne Precautions.Interview was conducted on February 8, 2026, at 1:20 PM with Licensed Nurse and Infection Preventionist (Employee E12). The employee reported that during feeding tube care, staff are only required to wear gloves (standard precaution). This employee confirmed that the facility does not acknowledge or implement CDC-recommended Enhanced Barrier Precautions (EBP). She stated that the facility currently utilizes only Airborne, Contact, and Standard Precautions. The employee was unaware of the indications for Enhanced Barrier Precautions and confirmed that staff have not been educated to wear gowns and gloves during high-contact care activities, as recommended by the CDC.Continued interview with the Infection Preventionist employee E12, documents were requested to review residents with facility-acquired infections over the past three months. The employee confirmed that she had not completed the required Pennsylvania reporting and therefore could not verify how many residents met the accepted criteria for facility-acquired infections. She stated that she randomly selects a few residents and applies the criteria, rather than reviewing all applicable cases, which results in inadequate infection surveillance practices and potentially inaccurate reporting of facility-acquired infections.Interview with nursing home administrator employee E1 and director of nursing employee E2 on February 8, 2026, at approximately 2:30 PM confirmed that the facility does not currently implement enhanced barrier precautions.Review of the midnight census report dated February 8, 2026, indicated that there are 146 residents in the facility. Of these, 16 residents do not require personal protective equipment (PPE) for enhanced barrier precautions. However, 130 residents who, according to CDC guidelines, require enhanced barrier precautions were noted as not currently having them in place. Review of the facility policy and procedures titled abuse dated April 9, 2024, revealed, it was the responsibility of the facility staff to ensure that each resident was free from abuse. The policy indicated each resident was to be protected from physical, mental, verbal, and sexual abuse. The policy further indicated each resident would be protected from neglect and harm while residing at the facility. The policy indicated abuse or neglect would not be tolerated at the facility. The policy indicated each resident was to be treated with respect and dignity. The policy indicated that all employees were to treat each resident in a manner that upholds a resident's sense of self-worth and individuality and does not perpetuate an environment of potentially abusive attitude toward residents.The policy defines neglect as the failure of facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Further review of policy revealed that . residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties.Review of undated facility policy and procedure titled incontinence care revealed it was the responsibility of the nursing staff to ensure that all residents who were incontinent of urine, feces or both, would be kept clean, receive timely, dignified and appropriate incontinence care aimed at maintaining skin integrity, promoting comfort and preserving dignity while preventing infection and complications.Review of facility policy titled Colostomy/ Ileostomy Care, states the purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. Review of facility grievance revealed that Resident R2 was found on his side with his face pressed into the mattress. The G-tube feeding valve had been ripped from the tube, causing tube feeding to spill onto the resident's clothing and linens. Red marks and bruising were noted across the left side of the body, and arm, with soiled linens containing urine and blood. A fresh wound dressing was noted on the sacrum post-care.The facility investigation determined the incident was substantiated. Statements from staff indicated that the wound care nurse had completed initial care and placed the resident on their side with clean dressings while instructing the nursing assistant (CNA) to finish care. According to staff, the CNA returned after rounds and found the resident left in the condition described.Interview (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Director of Nursing on February 10, 2025, confirmed the substantiated investigation.Review of facility provided grievance report, completed on November 20, 2025, by facility's grievance officer - employee E14, revealed that R25 was found on morning of November 20, 2025 soaked in urine, it did not appear he had been changed all night.Further review of grievance report revealed that per the camera review the resident was changed at 2:30 am and not again until day shift went in at 7:00 am. The resident (R25) received full care at 7:00 am and the 11-7 nurse aide (employee E13), received a written education regarding rounding on residents.Further review of facility provided documentation revealed that nurse aide, employee E13, received education regarding two-hour rounding on November 25, 2025; further review of this training provided by assistant director of nursing, revealed employee refused to sign acknowledgment of education received.Review of facility grievance, dated December 9, 2025, revealed the morning shift was concerned when they came in and found that the resident's colostomy bag was completely full and resident appeared to have to receive a bed bath. Further review of document revealed under Summary of Investigation an outcome of substantiated.Review of Resident R26's care plan, date revised October 16, 2025, indicated Resident R47 has a history of refusing care in the following areas: treatment administration. Interventions include: If refusing or resisting try again later. Notify physician and Responsible party of resident refusals of care and document: include attempts to re-educate. Document each instance of refusal and reason provided. Review of Resident R26's physician orders, dated October 2, 2025, Empty colostomy bag, every night shift. Review of Resident R26's clinical record revealed no documented evidence that resident refused care prior to incident. Review of facility investigation revealed interview with Employee E3, Licensed Practical Nurse stating [Resident R26] was refusing care. [NAME] went in and I went in to try to convince her, she still told us no. I am sorry I should have written a note. We went in so many times and she told us no. Review of Resident R26's TAR (Treatment Administration Record) revealed that on December 9, 2026, ileostomy care was provided to the resident during shift. Interview with Employee E2, Director of Nursing on February 11, 2026, at 1:15 p.m. confirmed findings that care was signed out, despite statement from nurse that care was not provided. Further interview confirmed no physician or responsible party notifications or educations related to refusals documented for resident. Review of grievance report dated November 21, 2025, filed on behalf of Resident R45 by Nursing assistant, Employee E17, revealed Employee E17 witnessed Resident R45 in bed, in the supine position, soaked in urine on the seven-to-three-day (7a.m-3p.m.) tour of duty on November 21, 2025. Review of grievance report confirmed Resident R45's neglect allegations were substantiated as a result of the nursing assistant, Employee E18 failure to provide care during the eleven to seven-night (11p.m - 7a.m.) tour of duty on November 21, 2025. Additional review of the grievance report revealed that according to camera footage, the nursing assistant was only in the bedroom of Resident R45 at 1:30 a.m., during her assigned night shift tour of duty. The nursing assistant, Employee E18 failed to provide the necessary services and care for Resident R45 who was incontinent of bowel and bladder and was totally dependent on two staff persons for personal hygiene and toileting. Interview conducted with nursing assistant Employee E17, at 10:00 a.m., on February 10, 2026, confirmed Resident R45 was found heavily saturated in urine, smelling highly saturated with urine at 7:10 a.m., on November 21, 2025. Employee E17 revealed that through observation, the resident did not receive bladder incontinence care at least every two hours, according to standards of practice for nursing care. Interview with the established grievance officer, Employee E14, at 11:00 a.m., on February 11, 2026, confirmed that the allegation of negligence for Resident R45 was substantiated on November 21, 2025, by nursing assistant, Employee E18. The grievance officer also confirmed that the Department was not notified of the possible abuse or neglect allegation for Resident R45 and failed to conduct a complete and thorough investigation to avoid emotional distress and mistreatment of Resident R45 on November 21, 2025, and other residents who did not receive timely care and services by the nursing assistant, Employee E18. Review of facility investigation revealed injuries include: right forearm- hematoma; right upper arm- right axilla bruise, purple superficial abrasion on right (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elbow, small yellowish green bruise posterior upper arm.Further review of facility investigation revealed Conclusion: The resident was observed with a hematoma on the right posterior forearm, as well as a small bruise on the right upper arm. A small bruise also noted on (his/her) right knee. The resident is dependent on staff for all care needs, has bilateral contractures, and a BIMS score of 0. (Resident) is also on anticoagulants which make (him/her) more susceptible to bruising. An investigation was completed and no perpetrator was identified. At this time, the investigation is closed with no substantiated findings.Interview on Employee E5, Unit Manager on February 10, 2026, at 12:35 p.m. revealed that bed rails have always been in place for the resident's safety We got the padding after those bruises on (his/her) arms showed up likely from us rolling (resident) and (his/her) arms hitting the side rail.Interview with Employee E2, Director of Nursing on February 10,2026 at 2:15 p.m., confirmed bed rails were in place during the time of incident. Further confirmed, as of August 15, 2025, no care plan interventions or documentation related to the padded side rails initiated. Review of grievance incident for Resident R100 revealed at approximately 3:30 p.m. The investigation included camera review, the resident was observed crying in the hallway. The facility investigation determined the resident had not been provided incontinence care during previous rounds, it was also observed through camera review the resident requesting assistance to be changed three times. Care was not provided until 3:45 PM.The facility investigation revealed that the camera review indicated that the assigned CNA spent an excessive portion of her shift-approximately 3.5 hours-at the nurse's station rather than providing resident care, per the report. The resident was observed receiving morning care around 8:00 AM, then removed from the room at 9:00 AM and placed in the hallway. Resident was returned to his/her room at 12:25 PM, then again placed in the hallway. At 3:30 PM, Resident R100 was crying in the hallway before finally receiving care. The facility concluded the investigation and determined it the investigation was substantiated, and nurse aide received education regarding proper care delivery. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to two Immediate Jeopardy situations. Refer to F600 and F880. 28 Pa Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(b)(3) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395019	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview and review of facility documentation, it was determined that the facility failed to ensure COVID-19 vaccination status of employees was tracked and documented in accordance with regulatory requirements. Review of facility records revealed that the facility was unable to provide documentation demonstrating that it tracked and recorded the COVID-19 vaccination status of facility staff, including whether staff were fully vaccinated, partially vaccinated, had approved exemptions, or had pending vaccination status as required by regulation. Interview with the Infection Preventionist, Employee E12 on February 8, 2026, at approximately 1:40 p.m., Employee E12 confirmed the facility did not maintain a system to consistently track and document employees' COVID-19 vaccination status in accordance with regulatory requirements. 28 Pa. Code 201.18 (1) Management 28 Pa. Code 201.19(5) Personnel Records

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	395019	A. Building B. Wing	02/12/2026

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Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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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. Based on observations of the operations within the food and nutrition department, interviews with staff, it was determined that essential equipment used to maintain the air temperature in the main kitchen was not fully functioning. Observations of the main kitchen at 9:45 a.m. and 11:45 a.m., on February 8, 2026, revealed that all dietary staff were wearing knit hats and sweatshirts while working in the main kitchen. The dietary staff were reporting that it was extremely cold in the kitchen over the past two months. Interview with a dietary aide, Employee E 20 revealed that it was a necessity to wear extra layers of clothing everyday while preforming dietary tasks due to the air temperature inside the kitchen presenting an uncomfortable work environment. Observations of the vent above the dish machine revealed that cold air was free flowing into the main kitchen form the outdoor winter weather. The exhaust fan was not properly functioning by way of pulling air out of the kitchen. Observations of the air temperature throughout the main kitchen with the maintenance director, Employee E24, at 9:15 a.m., on February 9, 2026, revealed a temperature range of 50 to 64 degrees Fahrenheit. Interview with the Director of Maintenance, Employee E24 at 9:20 a.m., on February 9, 2026, revealed that the large heating unit inside the main kitchen was not fully operational due to its' antiquated status. It was confirmed that this essential piece of equipment (heating unit) was not functioning in order to provide heat and a comfortable air temperature level for dietary staff to perform essential functions within the kitchen. 28 Pa. Code 201.18(b)(3) Management 28 Pa Code 205.61(a) Heating requirements for existing construction

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	395019	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations of the physical environment throughout the facility, reviews of pest control visits and interviews with staff, it was determined that the facility failed to maintain an effective pest control program to ensure that the building was pest free, in one of three nursing units (200 nursing unit) and in the food and nutrition department.Findings include: Observations of the 200-nursing unit 10:15 a.m., on February 8, 2026, revealed that the double metal doors leading directly outside the building were not sealed properly. The threshold of the door allowed easy access for pests and rodents to enter the facility. A two-inch gap was observed at the bottom of the metal doors upon closing. Interview with the maintenance director, Employee E24 at 9:15 a.m., on February 9, 2026, confirmed the repairs necessary to prevent pests and rodent entry. Observations of the main kitchen of the food and nutrition department revealed that mice droppings were identified around the perimeter of the flooring throughout the dry food storage area. The dry food storage room contained a wall mounted heating unit located directly underneath the double windows that was not operating. Interview with the maintenance director, Employee E24 at 9:15 a.m., on February 9, 2026, revealed that the panel and mechanical parts of the heating unit were scheduled for removal and observation to determine rodent nesting and breeding inside the heating unit, allow easy access to the dry food storage area and building. Observations of the double doors leading directly outside the main kitchen to the loading, receiving and trash and refuse area of the building revealed that the doors were not completely sealed upon closing. There was a two inch gap in the middle of the threshold of the doorway. This would allow easy access to the building for pests and rodents. A review of the pest control operator's visits for January 7, 16, 21 and 29, 2026 revealed that the main kitchen was inspected, food debris was found around sinks and walls. traps were routinely placed for rodents in the main kitchen, especially near sinks. The dry food storage area was treated for the continued presence of rodents (mice). A fly light was found to need replacement above the ice machine. A review of the pest control operator's visit for January 4, 2026, revealed that rodents (mice) were a problem that required routine placing of interior traps and glue boards for the building. Interview with the Director of Dietary Services, Employee E22 at 9:20 a.m., on February 9, 2026, confirmed that rodents (mice) sightings in the main kitchen have been problematic for January and February 2026. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1) Management