STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395050	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garvey Manor	1037 South Logan Boulevard Hollidaysburg, PA 16648

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medications (medications that affect the persons mental state, emotions and behavior) and the treatment alternatives prior to initiating the administration of the medication for one of 43 residents reviewed (Resident 47). Findings include: A facility policy related to psychotropic medications, dated June 20, 2025, indicated that once it is determined that a psychotropic medication will be initiated and/or increased, the resident and/or representative will be informed of the rationale for the medication order, the benefits/risks associated with the medication use, and of alternatives for the medication. Consent for use of and the education of the resident and/or resident representative regarding the medication order must be documented in the medical record prior to initiation of the medication. Informed consent will be documented in the medical record using the psychotropic UDA. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 47, dated March 11, 2026, indicated that the resident was cognitively impaired, was dependent of staff for daily care needs, received psychotropic medications including antipsychotic medications (medications used to treat mental health disorders), antianxiety and antidepressant medications, and had diagnoses that included dementia, anxiety, and depression. A psychiatry note for Resident 47, dated May 5, 2026, 1:00 a.m. revealed that the resident had a failing gradual dose reduction (GDR) of risperidone (Risperdal) due to increased verbal aggression and that the discontinuation of the risperidone had a rebound of verbal aggression and the power of attorney reported the resident's anger towards him which was an actual change from the resident's prior baseline. Recommendations were made to reorder risperidone 0.5 milligrams (mg) daily at bedtime for verbal aggression. A nursing note for Resident 47, dated May 14, 2026, at 1:10 p.m. revealed that the physician ordered to restart risperdal 0.5 mg daily at bedtime for agitation. Physician's orders for Resident 47, dated May 14, 2026, included orders for the resident to receive 0.5 mg of Risperidone daily at bedtime for agitation. There was no documented evidence in Resident 47's clinical record to indicate that the resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the Risperidone. Interview with the Director of Nursing on June 3, 2026, at 4:18 p.m. confirmed that there was no documented evidence in Resident 47's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the Risperidone. She indicated that as of May 18, 2026, they started doing a form explaining the risks and benefits. Prior to that, they were notifying families of the order changes, but not explaining risks and benefits and alternative interventions. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on review of facility policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for one of 43 residents reviewed (Resident 21). Findings include: A review of a facility policy regarding physical and functional needs, dated June 20, 2025, indicated that call bells are always kept within reach of the resident unless otherwise indicated in their plan of care. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 21, dated March 26, 2026, indicated that the resident was usually able to make herself understood and could usually understand others, had cognitive impairment, required moderate assistance from staff for transfers from bed/chair and chair/bed and toilet transfers, required moderate assistance from staff with ambulating, had a fall since the previous assessment without injury, had a motion sensor alarm used daily and had diagnoses that included dementia and orthostatic hypotension (low blood pressure when standing quickly). A fall care plan for the resident, dated July 6, 2023, included an intervention to keep the call bell within reach/ vision when in room. Encourage the resident to use the call bell and wait for assistance, and answer promptly as able. Observation of Resident 21 on June 1, 2026, at 2:10 p.m. revealed that the resident was sitting in her recliner chair to the left of her bed. There was a motion alarm on door frame to bathroom pointed in the direction of the bottom of the resident's bed/footboard and this writer set the alarm off when standing at the bottom of the resident's bed and directly in front of the resident while she was sitting in the recliner. A staff member came into the room and shut the alarm off and exited the room. A bruise was observed to the left side of her face and the resident stated it was from a fall. Her rollator walker was in reach, and she stated that she takes herself to the bathroom if she needs to go. This writer asked that resident if she could ring her call bell for assistance if needed and she picked up her phone that was on her overbed table. Her call bell was on her bed to the upper right side of her bed and not in reach of the resident. Interview Licensed Practical Nurse 1 on June 1, 2026, at 2:22 p.m. indicated that Resident 21 had fallen about two weeks ago. He stated that she is not supposed to take herself to the bathroom and that she is supposed to ring her call bell for assistance. He stated that sometimes she rings it and sometimes she doesn't, but she is able to use her call bell. He confirmed that the call bell was not in reach and should have been. While in the resident's room and confirming the call bell placement with Licensed Practical Nurse 1 this writer and the Licensed Practical Nurse set the motion alarm off while standing at the bottom of the resident's bed/footboard. Interview with the Director of Nursing on June 1, 2026, at 3:03 p.m. confirmed that Resident 21's call bell should have been in reach. She indicated that sometimes the resident gets in and out of bed herself and could have walked to the recliner without assistance, leaving the call bell on the bed where it would have been in reach if she were still in bed. It was noted, however, that the motion alarm sounds when motion is detected at the end of the bed/footboard and the resident would have had to walk past the end of her bed to get to her recliner sounding the alarm. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the attending physician and legal representative was notified concerning a change in condition for one of 41 residents reviewed (Resident 53). Findings include: The facility's policy for Change in Condition Reporting, dated June 20, 2025, indicated that the facility shall promptly notify the resident, his/her attending physician and legal representative of changes in the resident's conditions and/or status. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated March 23, 2026, revealed that the resident was cognitively impaired, dependent on staff for his daily care needs, and had diagnoses of benign prostatic hyperplasia (a non-cancerous condition that causes the prostate to enlarge and obstruct urine flow). A care plan for Resident 53, dated August 12, 2024, indicated that Resident 53 had the potential for complications with urinary elimination and required assistance with toileting. Staff was to observe for and document any signs and symptoms of infection such as frequency, burning, pain or discomfort. A nursing note for Resident 53, dated May 29, 2026, at 9:36 a.m. revealed that the resident complained of burning upon voiding and flank pain. Resident does have increased confusion and is afebrile at this time. Fluids encouraged, will continue to monitor. A nursing note for Resident 53, dated May 30, 2026, at 7:07 a.m. revealed that the resident complained of burning upon voiding. A nursing note for Resident 53, dated June 1, 2026, at 1:48 p.m. revealed that the resident complained of burning with urination and had a temperature of 95.9 degrees Fahrenheit (F). A physician communication report dated June 3, 2026, revealed that Resident 53 had been noted to be displaying increased confusion since May 15, 2026. Noted to have subtherapeutic temperatures as 91 and 95 degrees F and complaints of dysuria and flank pain. There was no documented evidence in Resident 53's clinical record to indicate that the attending physician and legal representative was notified promptly concerning the changes in the resident's conditions and/or status. An interview with the Director of Nursing on June 3, 2026, at 3:43 p.m. confirmed that the physician and legal representative was not notified promptly concerning Resident 53's change in condition and they should have been. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out abuse or neglect for one of 43 residents reviewed (Resident 6). Findings include: A facility policy regarding abuse reporting, dated June 20, 2025, indicated that all covered individuals (owner, personnel, volunteers, agents and contractors) must promptly report any incident or suspected incident of resident abuse, neglect, exploitation, including injuries of an unknown source suspected to be abuse, misappropriation of resident property, and any actions toward a resident which may be considered a crime by local or state laws. An injury should be classified as an injury of unknown source when both of the following criteria are met: the source of the injury was not observed by any person or the source could not be explained by the resident, and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. Upon review of the incident and investigation results, the facility will analyze the occurrence to determine why the incident occurred and what changes are needed to prevent further occurrences. How care provisions will be changed or improved to protect residents receiving services will be identified and implemented. Staff will be trained on changes made as a result of the incident and staff competency regarding the training will be completed. In this incident response, the staff responsible for implementation and those responsible for monitoring the implementation will be identified, as well as an expected date for implementation. Inquiries concerning abuse reporting and investigation should be referred to the Administrator, the Director of Nursing Services, and/or the Social Services Department. A facility policy regarding change in condition reporting, dated June 20, 2025, indicated that the registered nurse supervisor/designee will notify the resident's attending physician when the resident is involved in any accident or incident. The registered nurse supervisor/designee will notify the resident's legal representative when the resident is involved in any accident or incident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 4, 2026, revealed that the resident was cognitively intact and was usually able to be understood and was able to usually understand others, was dependent on staff for daily care needs, was incontinent of bowel/bladder, had two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar not present on admission, and had diagnoses that included cancer, morbid obesity, hemiplegia and hemiparesis following cerebral infarction and diabetes. A social services note for Resident 6, dated March 3, 2026, at 2:41 p.m. revealed that the resident was yelling out repeatedly Help me, and ouch. The writer of the note visited with the resident, and she showed her a bruise on her left hand which was hurting her. She could not recall how she got it and the team lead was made aware. There was no documented evidence that the bruise was investigated to rule out abuse and no documented evidence that the physician and resident representative were made aware. Interview with the Social services Director on June 3, 2026, at 12:02 p.m. confirmed that she did report the bruise on Resident 6's left hand to the team lead on March 3, 2026, but she could not recall who it was. Interview with the Director of Nursing on June 3, 2026, at 11:38 a.m. confirmed that she was not made aware of the bruise on Resident 6's left hand and there was no investigation completed and there should have been. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 43 residents reviewed (Residents 1 and 6).Findings include: A facility policy regarding care plans, dated June 20, 2025, indicated that resident care plans are reviewed or modified at least quarterly or upon a significant change in the resident's condition, or according to the target date indicated on the care plan. When immediate need care plan problems resolve or stabilize, the immediate need care plan may be resolved or incorporated into the core care plan. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 13, 2026, revealed that the resident was cognitively intact, wore hearing aids, understood and could understand others, required assistance with care needs, had diagnoses that included end stage renal disease and received dialysis (filtering the blood of toxins) on Tuesday, Thursday and Saturday through a hemodialysis catheter (a flexible tube placed in the neck or chest, to provide temporary access for cleaning blood during dialysis.Observations and an interview with Resident 1 on June 3, 2026, indicated that she had a hemodialysis catheter in her right upper chest and no fistula (surgically created access device created to provide access during dialysis) in her right upper arm.A care plan for Resident 1 dated April 6, 2026, indicated that the staff was to observe the resident's fistula every shift and upon return from dialysis.Interview with the Nursing Home Administrator on June 3, 2026, at 10:54 a.m. indicated that Resident 1's care plan should have been revised to reflect that she did not have a fistula in her right arm.A significant change MDS assessment for Resident 6, dated January 15, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included anxiety and bipolar disorder. A care plan for the resident, A quarterly MDS assessment for Resident 6, dated May 4, 2026, revealed that the resident was cognitively intact and was usually able to be understood and was able to usually understand others, was dependent on staff for daily care needs, was incontinent of bowel/bladder, received hospice care, and had diagnoses that includedchronic kidney disease stage 3 (moderate to severe loss of kidney function) and obstructive sleep apnea. A care plan for Resident 6, dated August 14, 2023, indicated that the resident had bilateral nephrostomy tubes (thin flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag). Review of the resident's clinical record revealed no documented evidence that the resident had bilateral nephrostomy tubes or had physician's orders related to bilateral nephrostomy tubes. A care plan for Resident 6, dated August 28, 2023, revealed that the resident had a diagnosis of sleep apnea and used a continuous positive airway pressure (CPAP) machine (delivers a steady, gentle stream of pressurized air through a mask, keeping your throat open so soft tissues don't collapse and block your airway while you sleep). Review of the resident's clinical record revealed no documented evidence that the resident had a CPAP machine or had physician's orders related to a CPAP machine. Interview with the Director of Nursing on June 3, 2026, at 11:38 a.m. confirmed that Resident 6's care plan should have been revised to reflect the she did not have nephrostomy tubes or a CPAP machine. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of 43 residents reviewed (Resident 9), and failed to ensure that psychiatric recommendations for medication changes were completed timely for one of 43 residents reviewed (Resident 47). Findings include: The facility's arm and leg protectors' policy, dated June 20, 2025, indicated that staff should follow physician's orders for arm and leg protectors. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 9, dated May 14, 2026, revealed that the resident was understood and could understood and was severely cognitively impaired. The resident's care plan, dated March 13, 2026, revealed that the resident was to always wear leg protectors except for during hygiene care to help prevent skin breakdown related to impaired skin integrity. Physician's orders for Resident 9, dated February 25, 2023, included an order for the facility to use protocols as indicated to prevent skin breakdown. Physician's orders dated March 13, 2026, included an order for total body skin checks twice a week, and a specialized pressure reducing mattress. Observations of Resident 9 on June 4, 2026, at 1:06 p.m. revealed that the resident was lying in her bed without her leg protectors on. Interview with Nurse Aide 2 on June 4, 2026, at 1:18 p.m. revealed that Resident 9 did not have her leg protectors on as indicated on the residents Activity of Daily Living (ADL) sheet. Nurse Aide 2 indicated that each resident has an ADL sheet in a folder on the back of their door. This resident specific sheet is updated regularly and has information regarding how to care for the residents. Nurse Aide 2 proceeded to look in the resident's room for the leg protectors and could not find them. Interview with the Nursing Home Administrator on June 4, 2026, at 2:20 p.m. confirmed that Resident 9 should have had her bilateral leg protectors on as ordered and care planned and she did not. The facility's policy regarding a change in condition, dated June 20, 2025, indicated that the facility shall promptly notify the resident, his/her attending physician and the legal representative of changes in the resident's condition and/or status. The Registered Nurse Supervisor/designee will notify the resident's attending physician when approval for consultations or consultation recommendations are necessary. For non-emergency situations, if no response (to the initial communication) is received from the physician within 24 hours, the nursing staff will reattempt communication with the physician via a phone call. Documentation of notifications and communications with the physician and/or legal representatives will be recorded in the progress notes of the medical record. A quarterly MDS assessment for Resident 47, dated March 11, 2026, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, had instances of rejection of care that occurred one to three days in the look-back period, received psychotropic medications (medications used to treat mental health disorders by altering brain chemistry) including antipsychotic medications (medications used to treat mental health disorders), antianxiety and antidepressant medications, and had diagnoses that included dementia, anxiety, and depression. A nursing note for Resident 47, dated May 2, 2026, at 2:16 p.m. revealed that the resident's son was in to speak with this nurse and communicated concerns that since discontinuing Risperdal (antipsychotic medication), the resident has had many changes including increased anger/agitation, anxiety, confusion, aggression, decreased appetite, weight loss, tearful episodes, and depression over the past six months. A communication was given to social services regarding his concerns to pass on to the psychiatric consultant. A psychiatry note for Resident 47, dated May 5, 2026, 1:00 a.m. revealed that the resident had a failing gradual dose reduction (GDR) of risperidone (Risperdal) due to increased verbal aggression and that the discontinuation of the risperidone had a rebound of verbal aggression and the power of attorney reported the resident's anger towards him which was an actual change from the resident's prior baseline. Recommendations were made to reorder risperidone 0.5 milligrams (mg) daily at bedtime for verbal aggression. Medication administration notes for Resident 47, dated May 6, 2026, at 3:08 p.m., and May 7, 2026, at 3:32 a.m., revealed that the resident was resistive to care. A nursing note for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 47, dated May 8, 2026, at 1:39 p.m. revealed that the nurse spoke with the son regarding the recommendation from Vital Psychiatry to restart risperidone due to an unsuccessful GDR. The son agreed with their recommendations. The recommendation was faxed to the physician for review and order. Medication administration notes for Resident 47, on May 10, 2026, at 2:57 a.m. revealed that the resident was resistive to care; on May 11, 2026, at 5:11 a.m. revealed that the resident was verbally aggressive with staff and resistive with care; and on May 12, 2026, at 2:57 a.m. revealed that the resident was resistive to care. A nursing note for Resident 47, dated May 13, 2026, at 8:51 a.m. revealed that the physician was called about restarting the resident on Risperdal per psychiatry recommendations and they were awaiting a return call. Medication administration notes for Resident 47, dated May 13, 2026, at 11:54 p.m. revealed that the resident was resistive with care. A nursing note for Resident 47, dated May 14, 2026, at 1:10 p.m. revealed that the physician ordered to restart Risperdal 0.5 mg daily at bedtime for agitation. Physician's orders for Resident 47, dated May 14, 2026, included orders for the resident to receive 0.5 mg of Risperidone daily at bedtime for agitation. There was no documented evidence in the clinical record to indicate that the psychiatric recommendations to restart Risperdal for Resident 47 were completed timely as per the facility policy. The initial communication with the physician occurred three days after the recommendations were made. The second attempt of communication with the physician occurred five days after the first communication attempt. The Risperdal was ordered eight days after the initial recommendation to restart the medication per the request of the resident's son and per the psychiatry recommendations. Interview with the Director of Nursing on June 3, 2026, at 4:18 p.m. indicated that the psychiatry recommendation to restart the Risperdal was faxed to the physician then the office was called when the nurse realized the physician did not respond to the fax. She confirmed that the recommendation should have been addressed sooner. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the physician of a wound that progressed to a pressure ulcer, failed to ensure treatments were in place to prevent the progression of pressure ulcers, and failed to ensure that pressure ulcer treatments were completed as ordered for one of 43 residents reviewed (Resident 6). Findings include: Review of a facility policy regarding wound management program, dated June 20, 2025, indicated that all wounds, skin abnormalities, pressure ulcers/injuries, non-pressure related ulcers/injuries, and surgical wounds shall be identified, assessed, treated, and monitored to promote healing and prevent infections. All pressure ulcers/injuries, non-pressure related ulcers, and/or wounds will have ongoing evaluation by the interdisciplinary team and/or the in-house wound physician. The team leader will complete a skin observation tool under the assessment tab in the medical record. This tool is then printed and given to the Registered Nurse (RN) supervisor for further assessment/evaluation of the need for treatment. The skin assessment tool is then forwarded to the skin care coordinator for further review and assessment. The physician will be notified of skin abnormalities. An assessment will be completed at least once every seven days until the wound is healed or until the resident is seen by the in-house wound physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 4, 2026, revealed that the resident was cognitively intact and was usually able to be understood and was able to usually understand others, was dependent on staff for daily care needs, was incontinent of bowel/bladder, had two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar not present on admission, and had diagnoses that included cancer, morbid obesity, hemiplegia and hemiparesis following cerebral infarction and diabetes. A nursing note for Resident 6, dated March 18, 2026, at 8:25 p.m. revealed that an open area was noted by staff during incontinent care. The RN assessed the area to the resident's mid lower sacral area (area at the base of the spine, situated just below the lower back and directly above the tailbone). A superficial open area was noted 0.4 centimeters (cm) length (L) by 0.3 cm width (W) x 0.1 cm depth (D). The RN directed the nurse aide in application of barrier cream to area as well as other buttock/peri areas. A skin observation tool was completed, and report was given to the skin care coordinator RN. A skin assessment tool for Resident 6, dated March 18, 2026, revealed that the resident had an open area to her sacral area noting it as questionable moisture associated skin damage (MASD). A nursing note for Resident 6, dated March 27, 2026, at 11:18 a.m. revealed that the resident had an open area to her coccyx area (tailbone) measuring 1.0 cm x 1.0 cm x 0.1 cm. The area was cleansed, calcium alginate AG (a dressing used to wounds with a high amount of drainage) was applied to wound bed and covered with an abdominal (ABD) pad (used for a wound with large amounts of drainage or used as padding for pressure points and cushioning). A positioning wedge was obtained for offloading. A skin assessment tool for Resident 6, dated March 27, 2026, revealed that the resident had a stage 2 pressure ulcer (pressure wound with superficial skin loss) to the right buttock/coccyx area There was no documented evidence in Resident 6's clinical record that the physician was notified of the wound to the residents sacral area identified on March 18, 2026, no documented evidence that the wound was assessed and identified by the skin care coordinator, no documented evidence that preventative measures were in place to prevent pressure ulcers, no documented evidence that the barrier cream was applied and no documented evidence that the wound was assessed weekly. Interview with the Director of Nursing on June 3, 2026, at 3:45 p.m. indicated that the skin care coordinator was made aware of the open area to the sacrum identified on March 18, 2026, and confirmed it was MASD, but did not document her assessment. She confirmed that there was no documented evidence that the physician was notified of the wound to the residents sacral area identified on March 18, 2026, no documented evidence that the wound was assessed and identified by the skin care coordinator, no documented evidence that preventative measures were in (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place to prevent pressure ulcers, no documented evidence that the barrier cream was applied and no documented evidence that the wound was assessed weekly. Physician's orders for Resident 6, dated March 28, 2026, revealed that staff were to cleanse the right coccyx area wound with normal saline (NSS-a sterile solution used for the moistening of wound dressings and wound debridement), pat dry, apply calcium alginate AG to the wound bed, and cover with an ABD pad folded in half. every day shift for wound care. A review of the resident's Treatment Administration Record (TAR), dated April 2026, revealed that there was no documented evidence that the resident's treatment was completed as ordered on April 3, 2026. Physician's orders for Resident 6, dated April 18, 2026, revealed that staff were to cleanse the sacrum wound with normal saline, pat dry, apply calcium alginate AG to the wound bed, and cover with small Allevyn (a padded foam dressing for added comfort) every day shift for wound care. A review of the resident's TAR, dated April and May 2026, revealed that there was no documented evidence that the resident's treatment was completed as ordered on April 20, April 26 and May 6. Physician's orders for Resident 6, dated May 12, 2026, revealed that staff were to cleanse the sacrum and right buttocks wound with one fourth strength Dakins (a solution used to treat and prevent tissue infections), pat dry, apply calcium alginate AG to the wound bed, and cover with small Allevyn every day shift and as needed. A review of the resident's TAR, dated May 2026, revealed that there was no documented evidence that the resident's treatment was completed as ordered on May 19, May 22, May 23, May 24, and May 25. Interview with the Director of Nursing on June 3, 2026, at 3:45 p.m. indicated that the nurse did do the treatments on the above-mentioned dates but forgot to sign the treatment record. She confirmed that there was no documented evidence that the treatments were completed to the resident's pressure ulcers on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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	395050	A. Building B. Wing	06/04/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, as well as review of clinical records and staff interviews, it was determined that the facility failed to ensure that neurological checks were completed per facility policy for a resident who sustained a head injury after a fall for one of 43 residents reviewed (Resident 24), and failed to ensure the environment remained as free from accident hazards as possible, by not completing elopement risk assessments quarterly per facility policy for one of 43 residents reviewed (Resident 115). Findings include: A facility policy related to neurological status monitoring, dated June 20, 2025, indicated that the neurological status of a resident will be monitored following suspected head trauma/injury. Parameters will be monitored every 15 minutes for two hours, every 30 minutes for two hours, every one hour for four hours, then every eight hours for 16 hours until 24 hours have passed, unless otherwise ordered by the physician. Neurological flow sheets found to be incomplete will result in repeat of 24-hour monitoring. If a resident is sent to the hospital for evaluation after the initiation of neurological checks, checks should resume as indicated on the time sheet at the appropriate time interval until 24 hours post fall has passed. A admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated August 26, 2025, indicated that the resident was cognitively impaired, required moderate assistance from staff with transfers, required supervision with walking 10 feet, used a wheelchair, had a history of falls in the month prior to admission and a fracture in the last six months prior to admission, and had diagnoses that included a left humerus fracture (break to upper arm bone). A nursing note for Resident 24, dated November 18, 2025, at 7:00 p.m. revealed that the resident had a fall in her bathroom at 6:15 p.m. and was observed lying face down on the floor, with her feet towards the commode. There was a moderate amount of blood noted on floor. The resident's nose appeared to be bleeding, she had a laceration above her right eyebrow that was bleeding, and she had a skin tear below her right eye. The resident was assessed by the registered nurse, her neurological checks were within normal limits, and she was sent to the hospital for an evaluation. A nursing note for Resident 24, dated November 19, 2025, at 3:30 a.m. revealed that the resident returned from the hospital and her neurological checks were within normal limits. Review of Resident 24's neurological checks form revealed that neurological checks were started on November 18, 2025, at 6:15 p.m. then the resident was sent to the hospital for an evaluation. The resident returned from the hospital on November 19, 2025, at 3:30 a.m. and neurological checks were resumed every 30 minutes and documented at 3:30 a.m., 4:00 a.m., 4:30 a.m., 5:00 a.m., 5:30 a.m. and 6:00 a.m. and then stopped. Per the neurological check form, the resident was on schedule to have her neurological checks completed every eight hours for 16 hours at the time of her return form the hospital. There was no documented evidence that the neurological checks were completed per the facility policy, and there was no documented evidence that the neurological checks were restarted since they were not completed per the instructions as per the facility policy. Interview with the Director of Nursing on June 4, 2026, at 11:21 a.m. confirmed that the neurological checks for Resident 24 were not completed as per the facility policy and they should have been. A facility policy for elopement risk, dated June 20, 2025, indicated that each resident will be assessed for elopement risk upon admission by the interdisciplinary care team using information acquired prior to admission, at admission and during completion of the initial MDS assessment, then quarterly or with significant change in status using an elopement evaluation completed by the assessment coordinator. A quarterly MDS assessment for Resident 115, dated May 14, 2026, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs and had a diagnosis of Alzheimer's disease (a progressive brain disorder that slowly destroys the ability to maintain daily life). Review of Resident 115's medical record revealed that she was admitted to the facility on [DATE]. 2023. An elopement risk assessment was completed upon (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission and Resident 115 did have wondering and exit seeking behaviors, which indicated an elopement risk. An elopement risk care plan dated June 10. 2023 was initiated with goals and interventions in place. Elopement risk assessments were completed quarterly in 2023 and 2024. There was evidence that an elopement risk assessment was completed March 12, 2025, however, there was no documented evidence that elopement risk assessments were completed quarterly for the remainder of 2025. Interview with the Director of Nursing on June 3, 2026, at 1:25 p.m. confirmed that elopement risk assessments for Resident 115 were not completed per the facility policy and they should have been. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(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 review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder) for two of 43 residents reviewed (Residents 47, 92). Findings include: The facility's policy regarding urinary catheters, dated June 20, 2025, indicated that the purpose of the policy was to ensure safe handling of the urinary catheter in order to reduce the risk of urinary tract infections. This would include ensuring that the catheter bag is in a catheter bag cover/dignity bag, and that the dignity bag and catheter tubing are off the floor. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 47, dated March 11, 2026, indicated that the resident was cognitively impaired, was dependent of staff for daily care needs, had an indwelling urinary catheter, and had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems). Physician's orders for Resident 47, dated June 5, 2026, included orders for a suprapubic catheter (an indwelling urinary catheter). Observations on June 1, 2026, at 1:54 p.m. revealed that Resident 47 was in a low bed, and her catheter drainage bag and tubing were lying in direct contact with the floor on the right side of the bed. A gray basin was observed under the resident's bed. Interview with Nurse Aide 3 on June 1, 2026, at 2:05 p.m. confirmed that Resident 47's catheter drainage bag and tubing were lying in direct contact with the floor. She indicated that they typically have the catheter bag rest in a basin so that it is not touching the floor. She indicated that her bed stays in the lowest position, so it is difficult to keep the bag off the floor; however, she did confirm that the catheter bag should have been in the basin. Interview with the Director of Nursing on June 1, 2026, at 3:03 p.m. confirmed that Resident 47's catheter drainage bag and tubing should have been off the floor and in a gray basin. A significant change Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was moderately cognitively impaired, had an indwelling urinary catheter and had diagnoses that included chronic kidney disease (loss of kidney function) with urinary retention. Physician's orders for Resident 92, dated April 29, 2026, included orders for an indwelling urinary catheter. In addition, staff is to ensure that the urine collection bag is positioned off the floor and is covered with a dignity bag for dignity and infection prevention. Observations on June 1, 2026, at 10:31 a.m. revealed that Resident 92 was lying on her low bed, and her catheter drainage bag was touching the floor on the right side of the bed. There was no catheter bag/dignity bag on the urinary drainage bag. Interview with Nurse Aide 4, on June 1, 2026, at 1:58 p.m. confirmed that Resident 92's catheter drainage bag should have had a dignity bag on it and should not been touching the floor. Interview with the Director of Nursing on June 1, 2026, at 3:04 p.m. confirmed that Resident 92's catheter drainage bag should have had a dignity bag on it and should not been touching the floor. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 43 residents reviewed (Resident 6). Findings include: A facility policy regarding controlled substances, dated June 20, 2025, indicated that when a controlled substance (C2-C4) is removed for administration and must be destroyed, the destruction and documentation must be witnessed by two licensed nurses. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 4, 2026, revealed that the resident was cognitively intact, received routine and as needed pain medication, received opioid medications (a controlled pain medication), and had a diagnosis of cancer. Physician's orders for Resident 6, dated February 19, 2026, included an order for the resident to receive 50 micrograms (mcg) of Fentanyl transdermal patch (a controlled pain medication administered through the skin) to be applied every 72 hours for pain for metastatic cancer. The Medication Administration Record (MAR) and a controlled drug count record (tracks each dose of a controlled medication) for Resident 6, dated February, April and May 2026, revealed that a Fentanyl patch was applied to the resident on February 15, April 11, April 17, May 11, and May 23. There was no documented evidence that two staff members witnessed and signed that the old patch was destroyed after removal on these dates. Interview with the Director of Nursing on June 4, 2026, at 10:37 p.m. confirmed that there was no documented evidence that two staff members witnessed and signed that Resident 6's old patches were destroyed after removal on the above-mentioned dates. 28 Pa. Code 211.9(a)(h) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to date insulin pens in one of three medication carts reviewed (C1 medication cart).Findings include: A facility policy regarding medication storage, dated [DATE], indicated that multi-dose injectables would be discarded per manufacturer's recommendations or one year from the date opened, whichever is less. If a specific expiration date for a particular drug was indicated, a sticker with date opened-date expired will be attached and filled out by nursing or pharmacy when appropriate. (Novolog, Novolog mix, and Lantus insulin vials: 28 days once opened. Novolin R, Novolin N, Novolin 70/30: 42 days once opened.)Physician's orders for Resident 17, dated [DATE], included an order for the resident to receive 24 units of Novalog Mix 70/30 subcutaneously with meals for diabetes mellitus (a chronic disease that causes high blood sugar levels).Observations of the C1 medication cart on [DATE], at 7:56 a.m. revealed a Novalog 70/30 multi-dose injectable pen for Resident 17 that was opened but not dated, and in use on [DATE]. Interview with Licensed Practical Nurse 5 at the time of observation confirmed that the pen should have been dated when opened, and it was not.Interview with the Director of Nursing on [DATE], at 3:42 p.m. confirmed that insulin pens should be dated when opened and in use.28 Pa. Code 211.9(a)(1) Pharmacy Services.28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that food was stored under sanitary conditions. Findings include:A facility policy regarding food storage June 20, 2025, revealed that food storage areas shall be maintained in a clean, safe, and sanitary manner.Observations in the walk in cooler area on June 1, 2026, at 9:23 a.m. revealed that there was a metal cart with two trays of red velvet cake with white icing. The metal cart was uncovered on one side, and the two trays of cake were not covered and exposed to air. There was a box of packaged sliced red onions. The manufactures' used by date was May 28, 2026. Interview with the Dietary Manager on June 1, 2026, at 9:25 a.m. revealed Interview with the Dietary Director at the time of the observation confirmed that rack cover should have been in place, and the sliced onions should have been discarded. The onions were special food for Memorial Day. 28 Pa. Code 211.6(f) Dietary Services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of established infection control guidelines and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for two of 43 residents reviewed (Resident 1,4). Findings include: CDC guidance on Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding hand washing/hand hygiene, dated June 20, 2025, revealed that staff were to hand sanitize after they removed their gloves. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 13, 2026, indicated that the resident was cognitively intact, was understood and able to understand others, required extensive assistance with care needs, and had left lower cellulitis (inflammation of the skin) with accompanying leg wounds.Physician's orders for Resident 1, dated June 1, 2026, included orders to cleanse the left lower leg area with saline solution pat dry, pack wound with calcium alginate ag (a wound dressing), cover with an abdominal pad and wrap every day shift.A care plan for Resident 1, dated April 6, 2026, revealed that the resident had actual impaired skin integrity. A care plan for Resident 1, revised June 3, 2026, revealed that the resident is on Enhanced Barrier Precautions with interventions to wear a gown and gloves for all direct contact with the resident.Observations of Resident 1's wound care on June 3, 2026, at 9:42 a.m. revealed that Registered Nurse/Skin Care Coordinator 6 and Nurse Aide 7 performed wound care without wearing the proper PPE. They wore gloves only.A quarterly (MDS) assessment for Resident 4, dated February 26, 2026, indicated that the resident was severely cognitively impaired, had unclear speech was usually understood and usually understands, required extensive assistance with care needs, had diagnoses that included a stroke, and had a gastrostomy (a tube placed in the stomach) tube (GT) for nutrition. Physician's orders for Resident 4, dated February 3, 2025, included orders to flush the resident's gastrostomy tube (GT) every six hours with 120cc of water.A care plan for Resident 4, dated October 22, 2024, revealed that the resident had a GT and was on Enhanced Barrier Precautions with interventions to wear a gown and gloves for all direct contact with the resident.Observations of Resident 4's GT water flushing on June 3, 2026, at 1:45 p.m revealed that Licensed Practical Nurse 5 did not have on the proper PPE, she wore gloves only. In addition, after she completed the water flushing, she did not hand sanitize post glove removal. Interview with Licensed Practical Nurse 5 on June 3, 2026, at 1:55 p.m. confirmed that Resident 4 was currently on EBP and she should have worn proper PPE and hand sanitized post glove removal.Interview with the Infection Control Nurse and Assistant Director of Nursing on June 3, 2026, at 2:20 p.m. and 3:06 p.m. respectively, confirmed that Resident 1 and 4 were currently on EBP and staff should have worn appropriate PPE as care planned and per policy while performing wound care, and providing GT water flushes. In addition, staff should have hand sanitized post glove removal after the GT water flushing, and they did not. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing Services.