STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395095	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Village	773 East Haverford Road Bryn Mawr, PA 19010

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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 0689 Level of Harm - 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 facility policy, facility documentation, clinical records, and staff interview it was determined the facility failed to ensure the resident environment remained free of accident hazards for one of 12 residents reviewed (Resident R47). This failure resulted in actual harm to Resident R47 who spilled a hot liquid on his/her thigh resulting in a burn. This deficiency was identified as past non-compliance.Findings Include: Review of facility policy Assisting the Resident with In-Room Meals revised December 2013 revealed staff should check that hot foods are hot (but not scalding temperature). Review of Resident R47's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 20, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of malnutrition (lack of sufficient nutrients in the body), muscle wasting, and muscle weakness.Continued review of Resident R47's comprehensive MDS dated [DATE], revealed the resident was cognitively intact and required setup or clean-up assistance with eating (helper sets up or cleans up).Review of Resident R47's clinical record revealed a nursing note dated October 3, 2025, indicating the nurse aide responded to Resident R47's room after hearing resident call out for help. Upon entry, it was observed that a bowl of chicken broth from the dinner tray had spilled onto Resident R47's lap.Review of facility documentation titled Burn incident report dated October 3, 2025, revealed the resident's soiled clothing was removed and the area was cleansed with cold water and cold compress was applied. A nursing assessment revealed a raised area to the left inner thigh, measuring approximately 30 centimeters (cm) (length) by 8 cm (width) in size. Resident R47 reported tenderness to touch.Review of facility documentation revealed a statement obtained on October 3, 2025, from Resident R47, which indicated that while attempting to hold his/her cup of soup he/she dropped it because it was too hot. Resident R47 reported that he/she yelled out and the nurse responded/assisted.Review of facility documentation revealed a written statement dated October 3, 2025, by nurse aide, Employee E10, that indicated the employee gave Resident R47 a bowl of soup and instructed the resident that the second bowl of soup on the meal tray was too hot and to wait to eat it. Nurse aide, Employee E10, reportedly left the room to assist other residents when he/she heard the resident cry out. Nurse aide, Employee E10, ran back to the room and Resident R47 told the nurse aide he/she picked up the soup that was identified as being too hot and it subsequently spilled onto Resident R47's thigh.Interview on February 11, 2026, at 12:37 p.m. with nurse aide, Employee E10, revealed two bowls of chicken broth were requested to be sent with Resident R47's dinner tray on October 3, 2025. Resident R47 was reportedly positioned upright in bed with the overbed table set-up over Resident R47's lap.Continued interview on February 11, 2026, at 12:37 p.m. with Nurse aide, Employee E10, revealed he/she delivered Resident 47 his/her dinner tray [which contained two bowls of chicken broth] and removed the lid of one bowl of soup, pushing it closer to the resident. Interview conducted on February 11, 2026, at 12:37 p.m. with Nurse aide, Employee E10, revealed he/she only partially lifted the lid off the second bowl of soup and instructed Resident R47 to wait to eat it, as the soup bowel was identified to be hotter of the two bowls. Nurse aide, Employee E10, described the second bowl of soup to be hotter due to the condensation/steam (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 0689 Level of Harm - Actual harm Residents Affected - Few	observed beneath the lid. Just after nurse aide, Employee E10, left the room he/she heard Resident R47 cry out and promptly turned around to assist the resident. Review of Resident R47's clinical record revealed a nursing note dated October 4, 2025, indicating the area was identified as a superficial burn and noted to be blistered and red.Review of Resident R47's clinical record including a nursing note dated October 6, 2025, revealed the area was observed to be very reddened and blistering. Warm to touch, and painful.Review of Resident R47's wound care consult dated October 8, 2025, revealed the resident was seen for an initial consultation for wound care services for burn to the left thigh. The wound type was described as a burn with partial-thickness depth exposure. The wound size was described as a clustered wound and measured 22 cm (length) x 40.4 cm (width) x 0.1 cm (depth). Resident R47 was noted wild mild transient pain during the wound assessment.On October 3, 2025, following the incident, the facility immediately implemented the following corrective action:Resident R47 immediately assisted the resident by removing soiled clothing and cooling the affected area. A nursing assessment was completed and the physician was notified. Treatment orders were implemented, including prescribed topical treatment and dressings. The resident's family was notified, and the resident was monitored for changes in condition until healing was observed.All residents were reviewed for potential risk related to hot liquids. A hot liquid safety screening was completed for residents receiving hot beverages or hot foods. Residents identified with potential risk now have appropriate supervision, assistance, or safety interventions in place per individualized care plans.The facility updated the residents care plan to include supervision and safety precautions when hot liquids are served. Staff must remove or loosen lids prior to tray delivery to ensure safe placement of hot items. Education was provided to nursing, dietary, and nurse aide staff regarding hot liquid safety, tray delivery procedures, and monitoring requirements for residents consuming hot food or beverages.The Director of Nursing or designee will audit tray delivery and hot liquid safety practices weekly for four weeks, the monthly for three months to ensure compliance. Care plans and hot liquid risk screenings will be reviewed for accuracy. Findings will be reported through Quality Assurance Program (QAPI) and additional education provided if concerns are identified.Review of facility documentation revealed the facility implemented a revised Hot Liquid Safety Policy and Procedure effective October 6, 2025, which included safe temperature standards, identification of high-risk residents, and service and assistance requirements.Review of facility documentation confirmed a full house audit was conducted to ensure all residents had a hot liquid safety assessment completed. Resident care plans were subsequently updated to reflect hot liquid safety interventions and supervision needs.Review of staff education and staff interviews revealed dietary staff were educated on safe food handling, monitoring temperatures before meal service, and review and demonstration on thermometer calibration.Continued review of staff education and staff interviews revealed education was provided to on removing the lids of all hot containers before fully serving. If residents request the food or drink to be heated the items must go to dietary to ensure proper temperature.Review of facility documentation confirmed weekly, and monthly tray delivery and hot liquid safety audits were conducted to ensure compliance. Audits included observance of a hot liquid, set-up assistance of item, placement, supervision, was the care plan followed and were any issues identified.This deficiency was identified as past non-compliance. 28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to discuss the risks/benefits in advance for newly admitted resident for two of five resident records reviewed (Residents R1, and R23).Findings include:A review of the clinical record for Resident R1 revealed an admission date of July 21, 2025, with diagnosis of acute respiratory failure with hypoxia, parkinsonism, shortness of breath, heart failure, type 2 diabetes mellitus, depression, hypoxemia and acute kidney failure. Further review of the clinical record indicated physician orders for Resident R1 that included the following medications: insulin glargine subcutaneous solution (100 units/mL), with instructions to inject 20 units in the evening for diabetes; pramipexole dihydrochloride 0.5 mg orally at bedtime for Parkinson's disease; Eliquis 5 mg orally twice daily for atrial flutter; nifedipine extended-release 30 mg orally once daily for hypertension; and metoprolol succinate extended-release 25 mg orally once daily for congestive heart failure (CHF). Continued review of Resident 1's clinical record revealed no documentation of the facility providing education to the Resident or Representative of the risks and benefits associated with the use of the medication, including side effects and other adverse reactions. An interview conducted on February 12, 2026, at 11:08 a.m. with the Administrator, Employee E1, Director of Nursing (DON), Employee E2, and Regional Nurse, Employee E3, confirmed that a review of the risks and benefits of Resident R1's medication and treatment was not conducted in advance with the resident or his/her representative at the time of admission on [DATE]. The review was subsequently conducted on September 18, 2025. A review of the clinical record for Resident R23 revealed an admission date of January 07, 2026, with diagnosis cognitive communication deficit, major depressive disorder and anemia. Further review of the clinical record indicated physician orders for Resident R23 that included the following medications: Lansoprazole 30 (milligrams) mg, Acetaminophen Tablet 325 mg, Fleet Enema 7-19 GM/118ML (Sodium Phosphates) Dulcolax Suppository (Bisacodyl), Mirtazapine Oral Tablet 7.5 MG (Mirtazapine).Continued review of Resident 23's clinical record revealed no documentation of the facility providing education to the Resident or Representative of the risks and benefits associated with the use of the medication, including side effects and other adverse reactions. An interview conducted on February 12, 2026, at 12:45pm with the Administrator, Employee E1, Director of Nursing (DON), Employee E2, and Regional Nurse, Employee E3, confirmed that a review of the risks and benefits of Resident R23's medication and treatment was not conducted in advance with the resident or his/her representative at the time of admission on [DATE]. The review was subsequently conducted on September 18, 2025. 28 Pa. Code 201.29(a) Resident Rights.28 Pa. Code 201.29(a) Resident Rights.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and review of clinical records, it was determined that the facility failed to provide the resident and their representative with a summary of the baseline care plan for two of three newly admitted residents reviewed (Resident R38, and R45).Findings:A review of the facility policy titled Care Plans-Baseline, last revised in March 2022, revealed that, a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forth-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care pf the resident that meet professional standards of quality care and must include a minimum healthcare information necessary to properly care for the resident including, but not limited to the following; initial goals based on admission orders and discussion with there resident/representative, physician orders, dietary orders, therapy services, social services, and PASSSAR recommendation, if applicable. Under bulletin 4 it further states, The resident and/or representative are provided a written summary of the baseline care plan in a language that the resident/representative can understand. On February 11, 2026, at 1:55 p.m., the Director of Nursing (DON), Employee E2, confirmed that residents or their representatives do not automatically receive a copy of the baseline care plan unless they specifically request one. On February 11, 2026, at 1:59 p.m., an interview was conducted with the Social Services Director, Employee E4, who also confirmed that a copy of the baseline care plan is provided only upon request. On February 11, 2026, at 2:11 p.m., an interview was conducted with Resident R38, who is alert and oriented. Resident R38 reported that she was not offered a copy of her baseline care plan upon admission to the facility on January 2, 2026. Review of Resident R45's Minimum Data Set (federally mandated resident assessment and care screening) dated November 15, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), peripheral vascular disease (narrowed arteries that reduce blood flow to the limbs), respiratory failure, and muscle weakness. Review of Resident R45's clinical record revealed a nursing note dated November 13, 2025, that revealed resident was a new admission with the following diagnosis of pain management. Review of Resident R45's pain evaluation dated November 14, 2025, revealed the resident received both scheduled and as needed pain medication, and the resident reported frequent pain over the last five days. Per the pain evaluation dated November 14, 2025, Resident R45 was identified as at risk for pain. Review of Resident R45's clinical record revealed no documented evidence a baseline care plan was developed and implemented with individualized goals and interventions for pain management. Review of Resident R45's Minimum Data Set (federally mandated resident assessment and care screening) dated November 15, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), peripheral vascular disease (narrowed arteries that reduce blood flow to the limbs), respiratory failure, and muscle weakness. Review of Resident R45's clinical record revealed a nursing note dated November 13, 2025, that revealed resident was a new admission with the following diagnosis of pain management. Review of Resident R45's pain evaluation dated November 14, 2025, revealed the resident received both scheduled and as needed pain medication, and the resident reported frequent pain over the last five days. Per the pain evaluation dated November 14, 2025, Resident R45 was identified as at risk for pain. Review of Resident R45's clinical record revealed no documented evidence a baseline care plan was developed and implemented with individualized goals and interventions for pain management. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical record, and resident interview, it was determined that the facility failed to implement interventions consistent with the resident's assessed needs to maintain acceptable parameters of nutritional status for one of 12 residents reviewed (Resident R19).Findings Include:Review of facility policy Weight Assessment and Intervention revised February 2021 revealed resident weight will be measured on admission and weekly for four weeks thereafter. Any weight change of 5% or more since the last weight assessment will be addressed by the Registered Dietitian.Review of Resident R19's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 31, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of cancer, diabetes mellitus, muscle wasting, and dysphagia (difficulty swallowing).Continued review of Resident R19's comprehensive MDS dated [DATE], revealed the resident had signs and symptoms of swallowing disorder such as holding food in mouth/cheeks and complaints of difficulty or pain with swallowing.Review of Resident R19's clinical record revealed a nutrition assessment dated [DATE], that Resident R19 was assessed at a weight of 149 pounds [obtained May 25, 2025] and was deemed at nutrition risk related to poor intake.Further review of Resident R19's clinical record revealed a nutrition note dated May 28, 2025, that Resident R19 requested more Ensure (oral nutritional supplement). Further review of the nutrition note revealed the Registered Dietitian recommended Ensure nutritional supplement three times per day to aid in weight maintenance.Review of Resident R19's clinical record revealed no documented evidence the nutritional supplement was provided per the dietitian recommendations. Review of Resident R19's weight summary revealed a documented weight of 120.5 pounds on June 10, 2025, reflecting a 19% weight loss since May 25, 2025.Review of Resident R19's clinical record revealed a nutrition note dated June 13, 2025, that Resident R19 sustained a 19% weight loss, was reassessed with a weight of 120.5 pounds and deemed underweight for range of age. Reassessment included use of Ensure nutrition supplement three times per day. Resident R19 was identified as at risk for malnutrition related to poor intakes and low body mass index (BMI).Review of Resident R19's clinical record revealed no documented evidence the nutritional supplement Ensure three times per day was provided per recommendations.28 Pa. Code 211.12 (d)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, review facility policies and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment in resident care areas for one of two nursing units observed (CE Unit).Findings include:On February 9, 2026, at 10:45 a.m., an observation conducted in Room CE40 revealed that Resident R35 was seated in (her/his) wheelchair. The resident's bed was without sheets, a blanket, or a pillowcase. Two clear trash bags were observed next to Resident R35. One bag contained soiled linens, and the other contained a soiled brief and used gloves. The resident's toilet was observed to be soiled with brown feces on the interior surfaces.Additionally, a wound VAC machine was also observed on the floor next to the window in Resident R35's room. According to the resident's family member, the wound VAC machine was no longer in use and had been left on the floor for several days. The family member stated that Resident R35 was no longer receiving treatment with the device.On February 9, 2026, at 10:58 a.m., the above observations were confirmed by Registered Nurse (RN), Employee E7. Employee E7 removed the two trash bags from the room and placed them in the designated soiled utility area. Further observation revealed that the toilet was clogged with feces. Employee E7 attempted to clear the obstruction; however, the water level in the toilet began to rise and did not drain appropriately. On February 10, 2026, at 9:39 a.m., an observation was conducted in Room CE45. Resident R6 was observed lying in bed receiving enteral feeding. The wall behind the bed, bedside dresser, bed rails, floor, and enteral feeding pole were observed to have dried brown and yellow feeding spills and drips present.This observation was confirmed the same day at 9:45 a.m. by the Regional Nurse, Employee E3.28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review and staff interview, it was determined that the facility failed to notify the State Survey Agency of an allegation of verbal abuse within 24 hours for one of 12 residents reviewed. (Resident R 41) Findings include: Review of Resident 41's Minimum Data Set (MDS-assessment of residents care needs) revealed a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact and able to accurately report concerns. Continue review of Resident R41's clinical record revealed that the resident's diagnoses include Type 2 Diabetes Mellitus (failure of the body to produce insulin) without complications, Dysphagia (difficulty swallowing), Muscle weakness, and other abnormalities of gait and mobility.Resident R41 revealed during interview conduct on February 9, 2026, at 12:19 PM that (he/she) was verbally abuse by staff.Facility Administrator (NHA) and Director of Nursing (DON) were notified of the allegation of verbal abuse presented by Resident #41 on February 9, 2026 at 1:46 PM.Review of the Pennsylvania Electronic State Reporting System revealed that it was not until February 11, 2026, that the facility submitted a report regarding verbal abuse involving Resident R41, which was not within 24 hours of the allegation, as required. 28 Pa Code 201.18(b)(3) Management 28 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 facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for two of twelve residents reviewed (Residents R31 and R6).Findings:A review of the clinical record for Resident R31 revealed an admission date of December 29, 2025, with a diagnosis of periprosthetic fracture around the internal prosthetic left hip joint.Nursing progress notes dated January 7, 2026, at 2:56 p.m., indicated that the resident was observed to have redness to her right heel during the shift. No visible open area was present at that time. The resident denied pain and itching. An order was entered for skin preparation to the right heel daily. A voicemail message was left for the physician. The resident is identified as her own responsible party.A review of the wound tracking sheet documented that on January 14, 2026, the resident was noted to have a right heel deep tissue pressure injury (DTPI) measuring 3.5 centimeters (cm) by 3.8 cm.A physician order dated December 29, 2025, indicated, Off-load bilateral heels as tolerated.A review of the comprehensive care plan dated December 29, 2025, did not reflect that a comprehensive care plan was developed to address the intervention to off-load bilateral heels as tolerated. Documentation indicated that the comprehensive care plan addressing this intervention was not developed until January 20, 2026.On February 11, 2026, at 2:40 p.m., the Regional Nurse, Employee E4, confirmed that a comprehensive care plan for the off-loading of bilateral heels was not developed until January 20, 2026. A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke caused by a blockage), muscle weakness, unspecified dementia, hemiplegia (paralysis of one side of the body), aphasia (impairment of communication), dysphagia (difficulty swallowing), and hypertension.On February 9, 2026, at 11:03 a.m., an observation with Registered Nurse Employee E7 confirmed that Resident R6 was receiving oxygen therapy at 1.5 liters per minute.On February 12, 2026, at 2:02 p.m., a review of the clinical record with the Director of Nursing (DON), Employee E2, confirmed that Resident R6 did not have a comprehensive care plan related to oxygen therapy in place prior to its last revision on January 19, 2026.28 Pa. Code 211.10 (c)(d) Resident care policies28 Pa. Code 211.12(d) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of five residents observed during medication administration pass (Resident R31).Findings include:A review of the facility policy titled Administering Medication Revised April 2019, revealed medication are administered in a safe and timely manner and as prescribed. It further indicated under bulletin #4. Medications are administered in accordance with prescribed orders, including any required time frame. A review of the clinical record for Resident R31 revealed an admission date of December 29, 2025, with diagnoses including asthma and chronic obstructive pulmonary disease (COPD).A review of the physician's order dated December 29, 2025, indicated that Resident R31 was prescribed Symbicort Inhalation Aerosol 160-4.5 mcg/act (budesonide-formoterol fumarate dihydrate), with instructions to inhale two puffs orally twice daily for COPD.On February 9, 2026, at 11:48 a.m. Resident R31 reported that (she/he) did nor received (her/his) inhalation aerosol puffs since last Friday, February 6, 2026, facility has notified (her/him) that they do not have the inhaler medication available.A progress note dated February 9, 2026, at 5:00 p.m., documented by Licensed Nurse (LN) Employee E11, stating: Symbicort Inhalation Aerosol 160-4.5 mcg/act, inhale 2 puffs orally twice daily for COPD. Med not available; on order.On February 10, 2026, at 9:56 a.m., an observation was conducted with Licensed Nurse, Employee E7. Employee E7 reported that the inhalation aerosol treatment had been administered that morning and documented as given for Resident R31. When asked to produce the inhaler, Employee E7 was unable to locate the inhaler in the medication cart. Employee E7 then stated that she would strike through the medication administration entry, as the treatment had not been administered.On February 10, 2026, at 10:12 a.m. an interview was conducted with Director of Nursing who also confirmed that Symbicort Inhalation Aerosol 160-4.5 mcg/act was not available to the resident R31.A progress note dated February 9, 2026, at 12:50 p.m., was documented by Employee E7 stating: Medication (inhaler) was not available for the morning medication pass. The medication was struck out and reordered, awaiting pharmacy delivery. The physician was notified, and the medication is on hold until delivery.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and interviews with residents, family members, and staff, it was determined that the facility failed to provide the necessary assistance with activities of daily living (ADLs) to maintain proper nail care for one of the 12 residents reviewed (Residents R6). Findings:A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke caused by a blockage), muscle weakness, unspecified dementia, hemiplegia (paralysis of one side of the body), aphasia (impairment of communication), dysphagia (difficulty swallowing), and hypertension (high blood pressure).Review of Resident R6's quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted periodically to plan resident care) dated November 18, 2025, revealed that Resident R6 was totally dependent on staff for activities of daily living to include hygiene, bed mobility, transfers, toilet use and showers.Continued review of the MDS revealed a Brief Interview for Mental Status (BIMS) not recorded which means the resident was unable to participate in the assessment due to severe cognitive impairment.On February 10, 2026, at 10:24 a.m., a telephone interview was conducted with the resident's representative, who reported that Resident R6's nails had been long and dirty in the past. The representative further stated that Resident R6 uses (his/her) left hand to scratch (his/her) neck and that (his/her) nails should be kept short.On February 11, 2026, at 1:50 p.m., an observation was conducted with the Director of Nursing (DON), Employee E2. The observation revealed that the resident had long fingernails on both hands, and the fingernails on the left hand were noted to be dirty.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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, and staff interviews it was determined that the facility failed to implement preventative care for a resident at risk of alterations in skin integrity for one of 12 residents reviewed (Resident R49).Findings Include:Review of Resident R49's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2026, revealed the resident was newly admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypoxemia (low blood oxygen levels), need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility.Continued review of Resident R49's MDS dated [DATE], revealed the resident was identified as at risk of developing pressure ulcers/injuries.Review of Resident R49's admission skin evaluation dated February 1, 2026, revealed the resident was assessed with erythema (superficial reddening of the skin) to his/her sacral area.Review of Resident R49's comprehensive care plan dated February 1, 2026, revealed the resident was at risk for alterations in skin integrity. Intervention dated February 1, 2026, revealed to use a pressure reduction device on bed/chair.Observations on February 9, 2026, at approximately 10:15 a.m. revealed Resident R49 was sitting in his/her wheelchair positioned next to the bed. Resident R49 complained of discomfort on his/her buttock area and requested repositioning. Further observations revealed no cushion or pressure reduction device was on Resident R49's wheelchair seat.Interview on February 9, 2026, at approximately 10:20 a.m. with Licensed Nurse, Employee E6, confirmed Resident R49 did not have a cushion or pressure reduction device on the wheelchair seat. Licensed nurse, Employee E6, subsequently went on to collect and apply the wheelchair seat cushion for Resident R49. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.12(d)(1) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and interviews with staff, it was determined that the facility failed to ensure enteral feedings were labeled in accordance with professional standards of practice, for one of one resident reviewed for tube feeding (Resident R6).Findings include:A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke caused by a blockage), muscle weakness, unspecified dementia, hemiplegia (paralysis of one side of the body), aphasia (impairment of communication), dysphagia (difficulty swallowing), and hypertension (high blood pressure).A review of the physician's order for Resident R6, dated September 16, 2025, indicated an enteral feeding order as follows: Glucerna 1.2 at a rate of 85 mL/hour for 18 hours, for a total volume of 1530 mL. Feeding to be initiated at 4:00 p.m. and discontinued at 10:00 a.m. each day.On February 9, 2026, at 11:06 p.m., an observation was conducted with Licensed Nurse (LN) Employee E7. The observation revealed that Resident R6 was in bed receiving enteral feeding. The feeding bag was not labeled with the resident's name, date, or time of initiation. The bedside table contained multiple enteral feeding caps that were observed to be unsanitary. Additionally, the enteral feeding bottle was empty; however, per the physician's order, the feeding should have been discontinued at 10:00 a.m.28 Pa Code 211.10(c) Resident care policies28 Pa Code 211.12(d)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations of care and services, and interviews with staff, it was determined that the facility failed to consistently provide respiratory care and supplemental oxygen as ordered by the physician for one of one residents reviewed. (Resident R6).Findings include:A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke caused by a blockage), muscle weakness, unspecified dementia, hemiplegia (paralysis of one side of the body), aphasia (impairment of communication), dysphagia (difficulty swallowing), and hypertension (high blood pressure).On February 9, 2026, at 11:03 a.m., an observation with Registered Nurse, Employee E7 confirmed that Resident R6 was receiving oxygen therapy at 1.5 liters per minute. The oxygen tubing was not labeled, and the filter behind the concentrator was dirty, with a layer of dust.On February 12, 2026, at 2:02 p.m., a review of the clinical file with the Director of Nursing (DON), Employee E2, confirmed that Resident R6 did not have a physician order for oxygen therapy.28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff interview it was determined that the facility failed to provide pain management consistent with a resident's assessed needs for one of 12 residents reviewed (Resident R45).Findings Include:Review of facility policy Pain - Clinical Protocol revealed with input from the resident, the physician and staff will establish goals of pain treatment.Review of Resident R45's Minimum Data Set (federally mandated resident assessment and care screening) dated November 15, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), peripheral vascular disease (narrowed arteries that reduce blood flow to the limbs), respiratory failure, and muscle weakness.Review of Resident R45's after visit summary from the hospital dated November 12, 2025, revealed oxycodone 10 milliliters (ml) solution was recommended as needed.Review of Resident R45's clinical record revealed a physician order dated November 13, 2025, to give oxycodone (opioid used to treat moderate to severe pain) oral solution 10 ml every 12 hours as needed for pain, and an order to give oxycodone oral tablet 5 milligrams (mg) every 6 hours as needed for severe pain.Review of Resident R45's clinical record revealed a nursing note dated November 13, 2025, that Resident R45 refused any Tylenol for pain and is waiting for his/her narcotics.Review of Resident R45's pain evaluation dated November 14, 2025, revealed the resident received both scheduled and as needed pain medication, and the resident reported frequent pain over the last five days. Per the pain evaluation dated November 14, 2025, Resident R45 was identified as at risk for pain.Review of Resident R45's medication administration record revealed on November 14, 2025, the resident complained of a pain level of 7 and the nurse subsequently provided the as needed (PRN) 5 mg oxycodone oral. Per the medication administration record, the effectiveness was noted as ineffective with a linked nursing note, dated November 14, 2025, that indicated the PRN administration of the oxycodone was ineffective and Resident R45 continued to be in pain.Continued review of Resident R45's clinical record revealed a progress note dated November 14, 2025, that the pharmacy was contacted regarding delivery of oxycodone oral solution. Per the nursing note, the pharmacist stated there was no script sent for the medication. The on-call physician was notified and phoned script into the pharmacy. It was confirmed with the pharmacy that the medication was going to be sent out that night [November 14, 2025].Review of Resident R45's clinical record revealed a nursing note dated November 14, 2025, that the resident complained of abdominal pain and discomfort further stating he/she was not pleased with pain regimen. Per the nursing note, the nurse explained to Resident R45 that the oral liquid solution of the oxycodone was unavailable and in the meantime oxycodone tablet form would need to be administered.Review of Resident R45's clinical record revealed a nursing note dated November 15, 2025, that the resident dialed 911 because he/she was unsatisfied with pain.Further review of Resident R45's clinical record revealed a nursing note dated November 16, 2025, that the resident returned from the hospital and requested to leave against medical advice.Review of Resident R45's medication administration record revealed Resident R45 never received the oxycodone oral solution per the hospital recommendations. Resident R45 continued to complain of pain and ineffectiveness of regimen.28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 211.12 (d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and review of clinical records it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident for one of 12 residents reviewed. Findings Include:Review of facility policy Medication Shortages/Unavailable Medications revealed when medications are unavailable the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider.Continued review of facility policy Medication Shortages/Unavailable Medications revealed a medication shortage is noted the nurse should notify the pharmacy and determine the status of the order. If the next available delivery results in a delay or missed dose in the resident's medication regimen the nurse should retrieve the medication from the emergency stock or request an emergency/stat delivery from the pharmacy. If an emergency delivery/emergency stock is not feasible, the licensed nurse should contact the attending physician and order orders which may include holding the dose, use of alternative medication, or a change in order.Review of Resident R49's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2026, revealed the resident was newly admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypoxemia (low blood oxygen levels), need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility.Review of Resident R49's clinical record revealed a physician order dated February 2, 2026, to administer carvedilol by mouth two times per day (scheduled for the morning and evening) for hypertension (high blood pressure).Review of Resident R49's medication administration record revealed from February 2, 2026, through February 6, 2026 (total of 10 doses) the carvedilol was omitted seven times and signed out with a code for other/see progress notes.Review of Resident R49's clinical record revealed nursing notes dated February 2, February 3, February 4, February 5, and February 6, 2026, that the facility was awaiting pharmacy or awaiting delivery of the carvedilol.Further review of Resident R49's clinical record revealed no documented evidence that the physician was made aware of the missed doses, that an alternate treatment was requested, or specific orders for monitoring while the medication was unavailable. Review of the clinical record revealed no documented evidence the licensed nurse determined the reason for unavailability, length of time medication is unavailable, and what efforts were attempted to obtain the medication.28 Pa. Code 211.9 (a)(1) Pharmacy Services.28 Pa. Code 211.9 (d) Pharmacy Services.28 Pa. Code 211.12 (d)(1) 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. Based on review of observation, resident and staff interviews, it was determined that the facility failed to properly secure a medication for one of 12 residents reviewed. (Resident R38).Findings include: A review of Resident R38's clinical record revealed an admission date of January 2, 2026, with a diagnosis of glaucoma (increase eye pressure resulting in the inability of fluid to drain from the inner eye). A review of the physician's order dated January 2, 2026, revealed an order for Dorzolamide HCl ophthalmic solution 2%, instill one drop in both eyes twice daily for glaucoma. On February 9, 2026, at 12:02 p.m., observation revealed the Dorzolamide HCl ophthalmic solution was located in Resident R38's bed. Resident R38 reported that the nurse left the medication at her bedside during the night shift. On February 9, 2026, at 1:59 p.m., an interview was conducted with Resident R38, who reported that at times nursing staff would give (her/him) eye drop medication and Resident R38 would administer the medication (herself/himself). On February 9, 2026, at 2:05 p.m., an observation was conducted with Registered Nurse, Employee E7. Two bottles of Dorzolamide HCl ophthalmic solution were observed-one in the resident's bed and one on the dresser across from the bed. Employee E7 reported that Resident R38 is unable to self-administer medications and that the medication should have been stored in the locked medication cart. On February 9, 2026, at 3:45 p.m. Director of Nursing, Employee E2 also reported that all medications for Resident R38 should be safely stored in the medication cart and Resident R38 is unable to self-administer medications. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.9(b)(c)(d) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff interviews it was determined that the facility failed to implement infection control standards related to the use of personal protective equipment and wound care for one of 12 residents reviewed. (Resident R5)Findings Include:Review of memo Enhanced Barrier Precautions in Nursing Homes from the Centers for Medicare & Medicaid Services dated March 20, 2024, revealed enhanced barrier precautions (EBP- involve gown and glove use during high-contact resident care activities) recommendations include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status.Review of facility policy Wound Care revealed staff should use disposable cloth to establish a clean field on resident's overbed table. The licensed staff should place all items to be used during procedure on the clean field and arrange the supplies so they can be easily reached.Further review of facility policy Wound Care revealed staff should wear sterile gloves when physically touching the wound or holding a moist surface over the wound.Review of Resident R5's comprehensive Minimum Data Set (federally mandated resident assessment and care screening) dated January 2, 2026, revealed the resident was admitted to the facility on [DATE], and had at least one or more unhealed pressure ulcers. Review of Resident R5's wound care consult dated February 2, 2026, revealed the resident had an abrasion to his/her left chest with wound care instructions to cleanse with normal saline, apply calcium alginate, and cover with a clean dry dressing with a frequency of daily and as needed.Wound care observation was conducted on February 9, 2026, at 11:00 a.m. with Licensed Nurse, Employee E8, for Resident R5's left chest wound. Licensed Nurse, Employee E8, wore gloves and a mask for personal protective equipment (PPE) during wound care. Observations during wound care for Resident R5 on February 9, 2026, at 11:00 a.m. revealed License Nurse, Employee E8, used sterile gloves to take scissors out of his/her scrubs pocket, use them to cut open the calcium alginate, and then further apply the clean bandage to the open wound.Interview on February 9, 2026, at 12:55 p.m. with Licensed Nurse, Employee E8, confirmed he/she should have applied a new/clean pair of gloves after using the scissors and before applying the clean bandage to the open wound. Further interview with Licensed Nurse, Employee E8, confirmed there was no signage posted on the resident's room door to indicate Resident R5 was on enhanced barrier precautions, and that the employee failed to wear a gown, as required, during wound care.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.12(d)(1) Nursing services

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff interviews it was determined that the facility failed to ensure the call light was within easy reach for one of 12 residents reviewed (Resident R49). Findings Include:Review of facility policy Answering the Call Light revised October 2010 revealed when the resident is in bed or confined to a chair, the call light should be within easy reach of the resident.Review of Resident R49's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2026, revealed the resident was newly admitted to the facility on [DATE], and had diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypoxemia (low blood oxygen levels), need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility.Review of Resident R49's comprehensive care plan dated February 2, 2026, revealed the resident had an activity of daily living self-care deficit related to physical limitations. Interventions dated February 2, 2026, revealed Resident R49 required extensive assistance from staff with toileting, transfers, bed mobility, and dressing.Observations on February 9, 2026, at 10:15 a.m. revealed Resident R49 was sitting in his/her wheelchair positioned next to the bed. Resident R49 complained of discomfort and requested repositioning. Further observations revealed Resident R49's call light was on the floor and out of reach.Interview/observation on February 9, 2026, at 10:20 a.m. with Licensed Nurse, Employee E6, confirmed Resident R49's call light was not within reach.Observations on February 11, 2026, at approximately 1:24 p.m. revealed Resident R49 was sitting in his/her wheelchair positioned next to the bed. Resident R49 complained about being thirsty and requested water. Further observations revealed Resident R49's call light was out of reach.Interview on February 11, 2026, at approximately 1:25 p.m. with nurse aide, Employee E12, confirmed Resident R49's call light was not within reach.Observations on February 12, 2026, at approximately12:22 p.m. revealed Resident R49 was sitting in his/her wheelchair positioned next to the bed. Resident R49 complained about being uncomfortable in the wheelchair. Further observations revealed Resident R49's call light was out of reach.Interview on February 12, 2026, at approximately 12:23 p.m. with Licensed Nurse, Employee E6, confirmed Resident R49's call light was not within reach.Observations on February 13, 2026, at 10:58 a.m. revealed Resident R49 was sitting in his/her wheelchair positioned next to the bed. Further observations revealed Resident R49's call light was out of reach.Interview on February 13, 2026, at approximately 11:00 a.m. with licensed nurse, Employee E8, confirmed Resident R48's call light was out of reach.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility policy, review of facility assessment and staff interview, the facility failed to ensure include the direct care staff and input from residents, resident representatives and family members when conducting the facility assessment.Findings include: A review of the facility policy titled Facility Assessment, last revised in June 2024, revealed that a facility assessment is conducted annually to determine and update the capacity to meet the needs of, and competently care for, residents during day-to-day operations, including nights, weekends, and emergencies. The policy further describes the team responsible for conducting, reviewing, and updating the facility assessment under bulletin #2. The team includes leadership and management, such as the Administrator, a representative of the governing body, the Medical Director, the Director of Nursing, and other department heads as needed. It also includes direct staff, such as RNs, LPNs/LVNs, nursing assistants, and a representative of the direct staff if applicable. Finally, the policy indicates that residents, resident representatives, and family members may also be part of the team. Review of the facility's facility assessment provided revealed a last revision date of December 8, 2025. There was no indication that the facility involved direct care staff and input from residents. During an interview conducted on February 13, 2026, at 1:00 p.m., the Administrator was asked who participated in the development and revision of the facility assessment. The Administrator stated that the leadership team conducted the facility assessment. When asked whether direct care staff, residents, or resident representatives provided input during the meetings in which the facility assessment was revised, the Administrator did not provide documentation or other evidence to demonstrate that such individuals participated in the process. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(c)(d)(1) Nursing services