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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amoroso Healthcare and Rehabilitation Woodridge	3625 North Progress Ave Harrisburg, PA 17110

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to treat each resident with respect and dignity and care for each resident in a manner that enhances his or her quality of life for one of four residents reviewed (Resident 2).Findings Include: Review of the facility's policy, titled Dignity, dated 2001, read, Residents are treated with dignity and respect at all times. Also, Resident goals, choices, preferences, values, and beliefs, are respected and honored.This begins at initial admission and continues throughout the resident's stay. Review of Resident 2's physician orders revealed diagnoses that included spinal stenosis (a condition characterized by the narrowing of spaces within the spine, putting pressure on the spinal cord and nerves) and hypertension (elevated blood pressure). Review of Resident 2's clinical record revealed an admission date to the facility on February 25, 2026. Review of a documented statement, dictated to the Director of Nursing, dated February 26, 2026, revealed that upon admission to the facility, Resident 2 was provided with a bedpan for use with toileting with assistance by staff and Resident 2's daughter. Review of the facility's Grievance/Concern form, completed by Resident 2's daughter, read the Nurse Aide (Employee 3), Encouraged Resident 2 to ?pee' in her brief and they will change her. The Grievance/Concern continued that Employee 3 put a pamper on her [Resident 2]. Review of a document titled Employee Progress Discipline Notification, dated February 26, 2026, revealed that Employee 3 was assigned to provide care to Resident 2, including toileting, and was subsequently suspended for three days for double briefing Resident 2 instead of offering the bedpan or assistance with ambulating to the restroom. An interview with the Director of Nursing on March 11, 2026, at 12:23 PM, confirmed Employee 3 was suspended and ultimately terminated from her position at the facility related to the care provided to Resident 2. 28 Pa. Code 211.12 (d) (1) (2) (5) Nursing services

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 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 policy review, document review, and staff interview, it was determined that the facility failed to ensure that the services provided met professional standards of quality for two of four resident records reviewed (Residents 1 and 4).Findings Include: Review of the facility's policy, titled Administering Medications, revised April 2019, read, Medications are administered in a safe and timely manner, as prescribed. The policy continued, The individual administering medications verifies the resident's identity before giving the resident his/her medications. Review of Resident 1's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD- a progressive, incurable, but treatable inflammatory lung disease causing obstructed airflow) and hypotension (abnormally low blood pressure). Review of Resident 4's clinical record revealed diagnoses that included respiratory failure (a critical condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide) and atrial fibrillation (a common heart condition characterized by an irregular, often rapid heart rate). Review of the facility's incident report dated March 1, 2026, read, as follows: [Resident 1] told this nurse that on evening shift Sunday, the LPN [licensed practical nurse/Employee 4] brought in medications for both her and her roommate [Resident 4], put them down on the bedside tables, and left. The report continued, [Resident 1's] roommate [Resident 4] noticed a pink and white pill in there she did not take, she said ?these are not mine' [Resident 1] stated ?I take a pink and white pill' they called the nurse [Employee 4] in who realized she gave them the wrong medications. An interview with the Director of Nursing on March 11, 2026, at 11:22 AM, revealed she was made aware of the medication error on the next day and confirmed Residents 1 and 4 did not take each other's medications. The interview also revealed that Employee 4 was an agency-contracted nurse and will not be returning to the facility for employment. 28 Pa. Code 201.18 (b) (1) Management28 Pa. Code 211.12 (d) (1) (2) (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 a review of clinical records and a staff interview, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice and the comprehensive plan of care for one of four residents reviewed (Resident 2).Findings Include: Review of Resident 2's physician orders revealed diagnoses that included spinal stenosis (a condition characterized by the narrowing of spaces within the spine, putting pressure on the spinal cord and nerves) and hypertension (elevated blood pressure). Review of Resident 2's clinical record revealed a recent hospitalization resulting in surgery to the spine. According to documentation, Resident 2's wound/incision required staples, and the care to the site should be open to air. Review of a document titled Employee Progress Discipline Notification, dated February 26, 2026, revealed that the Nurse Aide (Employee 3) assigned to provide care to Resident 2 was suspended for three days for double briefing Resident 2 with the knowledge that the surgical site needed to be open to air. An interview with the Director of Nursing on March 11, 2026, at 12:23 PM, confirmed Employee 3 was suspended and ultimately terminated from her position at the facility related to the care provided to Resident 2, and confirmed Resident 2 should not have been provided with briefs covering the surgical site. 28 Pa. Code 201.18 (b) (1) Management28 Pa. Code 211.12 (d) (1) (2) (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 policy review, clinical record review, and staff interview, it was determined that the facility failed to provide routine drugs to its residents and provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one of the four residents reviewed (Resident 2).Findings Include: Review of the facility's policy, titled' Policy Services Overview, revised April 2019, reads, in part, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. The policy continued, Pharmacy services are available to residents 24 hours a day, seven days a week. Also, Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency, or as needed) in a timely manner. Review of Resident 2's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and muscle weakness, with an admission date to the facility on February 25, 2026. Review of Resident 2's Medication Administration Record (MAR), dated February 1 through 28, 2026, revealed the following medication order: Amlodipine Besylate give 5 mg by mouth one time a day related to essential hypertension (primary). Review of the MAR revealed that on February 26, 2026, the medication was not administered by the nursing staff as ordered by Resident 2's physician. Additional review of Resident 2's MAR revealed the following medication order: Valsartan-Hydrochlorothiazide oral tablet 320-25 MG, Give 1 tablet by mouth one time a day related to essential hypertension (primary). Review of the MAR revealed that on February 26, 2026, the medication was not administered by the nursing staff as ordered by Resident 2's physician. Review of Resident 2's progress notes, dated February 26, 2026, regarding those medications not administered, read Awaiting delivery. RN [Registered Nurse] Supervisor, RP [Resident Representative], and provider aware. An interview with the Director of Nursing on March 11, 2026, at 11:28 AM, revealed an acknowledgment that those medications ordered for Resident 2 were not available from the contracted pharmacy. The interview also revealed that the facility has contracted pharmacy services with another provider to prevent medication shortages for its residents. 28 Pa. Code 211.12 (d) (5) Nursing services