STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395142	A. Building B. Wing	11/26/2025

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a resident's medication regimen was free from unnecessary psychotropic medications for one of five residents reviewed for unnecessary medications (Resident 9).Findings include: Review of facility policy, titled Psychotropic Medication Use, with a last review date of May 21, 2025, revealed, in part, Assessment and Evaluation of the Resident: 1. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. 2. Circumstances that warrant an evaluation of the resident's underlying medical condition and medications include: a. admission or readmission; c. an irregularity identified during the drug regimen review. Behavioral and Other Non-Pharmacological Interventions: 1. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support gradual dose reduction. Informed consent: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives; b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representatives right to accept or decline treatment. Dose, Duration, and Duplicate Therapy: 3. Duplicate therapy (use of two or more medications of the same pharmacological class or category .) is generally not indicated unless there is a documented clinical rationale for the use of multiple medications from the same class or with similar effects. 5. Medications prescribed by a specialist or began in another care setting, such as the hospital, must be clinically indicated and documented in the resident's medical record. Review of facility policy, titled Medication Regimen Reviews, with a last review date of May 21, 2025, revealed, in part, Timeframe for Reporting: 3. The consultant pharmacist provides the director of nursing and medical director with a written, signed, dated copy of all medication regimen reports. 4. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. Physician Response: 1. Upon receiving the MRR [Medication Regimen Review] report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. 2. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. Review of Resident 9's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Resident 9's current physician orders revealed orders for duloxetine (a medication used to treat depression) 60 milligrams one capsule daily, dated June 19, 2025; mirtazapine (a medication used to treat depression)15 milligrams one tablet at bedtime, dated June 19, 2025; sertraline (a medication used to treat depression) 150 milligrams daily, dated June 19, 2025; quetiapine (a medication used to treat psychotic disorders) 100 milligrams administer one and a half tablets at bedtime, dated June 19, 2025; quetiapine 25 milligrams administer one tablet one time daily, dated September 5, 2025; and consult psychiatry to evaluate and treat as needed, dated August 21, 2025. Review of Resident 9's clinical record failed to reveal any documentation that education was provided to Resident 9 or her Representative regarding the risk versus benefit of the ordered antipsychotic and antidepressant medications or that consent was obtained to administer the medications. Review of Resident 9's clinical record failed to reveal any documentation of Resident 9's identified target behaviors, any behavior monitoring for the use of the antipsychotic medication, or any side effect monitoring of the antipsychotic medication. Review of Resident 9's care plan failed to reveal any identified target behaviors. Review of Resident 9's clinical record revealed that the facility consultant pharmacist issued a recommendation to Resident 9's physician on July 15, 2025, which indicated, in part, Black box warning .Residents with dementia-related psychosis treated with atypical antipsychotics are at an increased risk of death .increased incidence of cerebrovascular adverse events (including fatalities) has been reported in elderly patients with

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy reviews, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure residents received a transfer notice with required included information upon transfer/discharge; failed to provide residents with a copy of the facility's bed hold policy for three of four residents reviewed for hospitalization (Residents 8, 12, and 85).Findings include: Review of facility policy, titled Bed-Holds and Returns last reviewed May 21, 2025, read, in part, 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). Review of facility policy, titled Transfer or Discharge, last reviewed May 21, 2025, revealed that subsection titled Transfer or Discharge Documentation in the Medical Record, stated, 1. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: .b. That an appropriate notice was provided to the resident and/or legal representative . Review of Resident 8's clinical record revealed diagnoses that included congestive heart failure (disease process that results in the decreased ability of the heart to pump blood through the body effectively) and chronic kidney disease (disease of the kidneys that affects kidney function). Review of Resident 8's clinical record revealed that on June 22, 2025, Resident 8 was sent to the hospital for an acute medical change in condition. Resident was admitted to the hospital and returned to the facility on June 26, 2025. Review of available documentation revealed no evidence that Resident 8 nor Resident 8's Representative Party were provided a notice of transfer or bed hold policy. Resident 8 was also transferred to the hospital for an acute medical change in condition on July 12, 2025. Resident 8 returned to the facility on July 16, 2025. Review of available documentation revealed no evidence that Resident 8 nor Resident 8's Representative Party were provided with a notice of transfer or bed hold policy. Review of Resident 12's clinical record revealed diagnoses that included vascular dementia (changes in the blood vessels of the brain that results in decreased ability to perform activities of daily living and decreased contact with reality) and atrial fibrillation (irregular heartbeat). Review of Resident 12's clinical record revealed that on August 23, 2025, Resident 12 was sent to the hospital after an acute medical change. Review of the available documentation revealed no evidence that Resident 12 nor Resident 12's Representative Party were provided a notice of transfer or bed hold policy. Review of Resident 85's clinical record revealed diagnoses that included infection following a procedure, dysphagia (difficulty swallowing), and repeated falls. Review of Resident 85's clinical record revealed he was transferred to the hospital for an acute medical change in condition on August 15, 2025. Resident 85 returned to the facility on August 21, 2025. Review of available documentation failed to reveal evidence that Resident 85 was provided with a notice of transfer or bed hold policy. Review of Resident 85's clinical record revealed he was also transferred to the hospital for an acute medical change in condition on August 31, 2025. Resident 85 returned to the facility on September 6, 2025. Review of available documentation failed to reveal evidence that Resident 85 was provided with a notice of transfer or bed hold policy. During an email correspondence with the Nursing Home Administrator (NHA) on September 30, 2025, at 2:15 PM, the surveyor revealed the concern with the facility not being able to provide the bed hold and transfer notices for Resident 85's aforementioned hospital transfers. The NHA revealed he agreed with the concern about the notices as he does not have proof that they were sent. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident assessment accurately reflected the resident condition for six of 19 residents reviewed (Residents 2, 4, 5, 7, 15, and 32).Findings include: Review of Resident 2's clinical record revealed diagnoses that included pressure ulcer of sacral region, stage 4 (injury to the skin and underlying tissue caused by prolonged pressure on the skin), hypertension (persistent high blood pressure), and schizophrenia (a chronic mental health condition characterized by disruptions in thought, perception, and behavior). Review of Resident 2's Annual MDS (Minimum Data Set- assessment tool utilized to identify residents' physical, mental and psychosocial needs) with ARD (assessment reference date- last day of the assessment period) of May 18, 2025, revealed under Section M- Skin Conditions, Resident 2 was marked no to indicate he was not at risk of a pressure ulcer. During an interview with the Director of Nursing (DON) on October 21, 2025, at 1:09 PM, she revealed the aforementioned MDS was coded incorrectly, and she would expect the MDS to be coded accurately. Review of Resident 4's clinical record revealed diagnoses that included chronic kidney disease stage 4 severe (longstanding disease of the kidneys leading to renal failure), vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), and adult failure to thrive (a past history of weight loss of more than five percent, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction). Review of Resident 4's physician orders revealed orders for a consistent carbohydrate diet with a pureed texture and thin liquids, dated December 10, 2024; and hospice services, dated January 7, 2025. Review of Resident 4's Quarterly MDS with the assessment reference date of March 26, 2025, revealed in Section K. Swallowing/Nutritional Status that Resident 4's was not coded as receiving a therapeutic diet; and in Section O. Special Treatments, Procedures, and Programs that Resident 4 was not coded as receiving hospice care. Review of Resident 4's Modified Quarterly MDS with the assessment reference date of June 26, 2025, revealed in Section O. Special Treatments, Procedures, and Programs that Resident 4 was not coded as receiving hospice care. Review of Resident 4's Quarterly MDS with the assessment reference date of September 24, 2025, revealed in Section K. Swallowing/Nutritional Status that Resident 4's was not coded as receiving a therapeutic diet; and in Section O. Special Treatments, Procedures, and Programs that Resident 4 was not coded as receiving hospice care. During a staff interview with the Nursing Home Administrator (NHA) and DON on October 1, 2025, at 11:29 AM, the DON confirmed that Resident 4's aforementioned assessments were coded inaccurately and that modifications would be completed. Review of Resident 5's clinical record revealed diagnoses which included atrial fibrillation (irregular heartbeat) and chronic respiratory failure (respiratory disease that results in decreased ability of the lungs to either oxygenate the blood or remove carbon dioxide from the blood). Review of Resident 5's physician orders revealed an order for olanzapine (atypical antipsychotic medication used to treat mental health conditions) 5 milligrams twice a day, which was active since January 29, 2025. Review of Resident 5's Quarterly MDS with an assessment reference date of May 4, 2025, revealed Section N - Medications was coded to reflect Resident 5 was not receiving an antipsychotic medication; however, review of Resident 5's medication administration record revealed that at the time of the Quarterly MDS, Resident 5 had been receiving the antipsychotic medication. During a staff interview on October 21, 2025, at approximately 1:10 PM, the DON confirmed that Resident 5's Quarterly MDS with assessment reference date of May 4, 2025, should have been coded to reflect Resident 5's use of an antipsychotic medication. Review of Resident 7's clinical record revealed diagnoses that included gastrostomy status (refers to the presence of an artificial opening in the stomach for feeding patients who cannot ingest food orally), feeding difficulties, and abnormal posture. Review of Resident 7's Quarterly MDS with ARD of August 4, 2025, revealed under Section K- Swallowing/Nutritional Status was marked yes to indicate he had received intravenous (IV) fluids during the look back period for the assessment. Review of Resident 7's clinical record failed to reveal notation that they received IV fluids during the lookback. During an interview with the DON on October 21, 2025, at 1:09 PM, she revealed the aforementioned MDS was coded incorrectly, and she would expect the MDS to be coded accurately. Review of Resident 15's clinical record revealed diagnoses that included acute and chronic respiratory failure with hypoxia (conditions where the lungs cannot adequately exchange gases leading to low oxygen levels and potentially high carbon dioxide levels) and encounter for palliative care (specialized medical care aimed at enhancing the quality of life for patients with serious illnesses). Review of Resident 15's clinical record revealed she was admitted to

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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. Based on policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living receives necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of 19 residents reviewed (Residents 18 and 83).Findings include: Review of the facility policy, titled Activities of Daily Living (ADL), Supporting with a last revised date of April 2025, and a last reviewed date of May 21, 2025, revealed 5. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care including appropriate support and assistance with: mobility (transfer and ambulation). Review of Resident 18's clinical record revealed diagnoses that included dysphagia (difficulty swallowing) and hypertension (high blood pressure). Review of Resident 18's comprehensive care plan revealed an ADL care plan with an intervention that Resident 18 requires total lift and 2-staff participation with transfers, with an initiation date of March 6, 2023, and a revision date of June 30, 2025. Another intervention included in Resident 18's ADL care plan includes that they prefer to be out of bed in their chair after they are changed, initiated on March 22, 2023, and revised on July 26, 2024. Further review of Resident 18's care plan revealed a focus area that there is a potential risk of adjustment due to resident age is younger than general population, with an initiation date of March 7, 2023, and a revision date of April 20, 2023; and an intervention that Resident 18 would like to arise at 7:00 AM and be put back to bed at approximately 9:30 PM - 10:00 PM. Interview conducted with Resident 18 on September 29, 2025, at 10:00 AM, the Resident revealed that the Resident was waiting to get up out of bed. Interview conducted with Employee 4 on September 29, 2025, at 10:02 AM, revealed that Resident 18 is hard to understand and that the Resident was waiting to get up. Observations of Resident 18 on September 29, 2025, at 10:20 AM, 11:14 AM, and 11:40 AM, revealed Resident 18 was still lying in bed waiting to get up. Observation at 11:47 AM revealed two staff members went into Resident 18's room with a lift to get them up out of bed. During an interview with the Nursing Home Administrator (NHA) on October 21, 2024, at 11:05 AM, he revealed he would have expected Resident 18's care plan to have been followed. Review of Resident 83's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 83's comprehensive care plan revealed an ADL care plan with an intervention that the Resident required total lift and 2-staff participation with transfers, initiated on February 14, 2024, and revised on July 26, 2024. Further review of Resident 83's care plan revealed a care plan for dialysis and an intervention that after Resident 83 returns from dialysis, to offer them rest period in bed (Resident request to be laid down after she gets back from dialysis), initiated on August 15, 2025. Observation conducted on September 30, 2025, at 1:04 PM, revealed Resident 83's call light was on. Interview conducted with Resident 83 on September 30, 2025, at 1:17 PM, revealed that she wanted to get put back in bed and has been back from dialysis since 11:00 AM, and does not feel well. Observation conducted on September 30, 2025, at 1:22 PM, revealed a staff member going into Resident 83's room and turning the call bell off and exiting the room. Interview conducted with Resident 83 on September 30, 2025, at 1:24 PM, revealed that the staff member told Resident 83 they will get someone to assist putting Resident 83 into bed. Observation on September 30, 2025, at 1:52 PM, revealed two staff members going into Resident 83's room with a lift to assist them into bed. During an interview with the NHA on October 1, 2025, at 10:52 AM, they revealed that they would expect Resident 18's plan of care to have been followed, and for Resident 83 to have been put back into bed upon returning from dialysis. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to provide interventions to prevent accidents for two out of 19 residents reviewed (Residents 4 and 83).Findings include: Review of the facility policy, titled Falls - Clinical Protocol, with a last revised date of March 2018, and a last reviewed date of May 21, 2025, revealed, The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff and physician will monitor and document the individual ' s response to interventions intended to reduce falling or the consequences of falling. Review of Resident 4's clinical record revealed diagnoses that included chronic kidney disease stage 4 severe (longstanding disease of the kidneys leading to renal failure), vascular dementia (brain damage caused by multiple strokes, which causes memory loss in older adults), and adult failure to thrive (a past history of weight loss of more than five percent, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction). Review of Resident 4's clinical record progress notes revealed that she had a fall from her bed on September 20, 2025. Review of Resident 4's clinical record progress note dated September 20, 2025, at 9:55 AM, that revealed that the facility had contacted Resident 4's hospice provider about providing Resident 4 with a different bed that could be positioned lower to the floor since the one that they had already provided could be positioned in this manner. In addition, a progress note dated September 20, 2025, at 10:29 AM, indicated that the facility had contacted Resident 4's Representative to update her on the incident. The note further indicated that Resident 4's Representative requested that Resident 4 be provided with a second body pillow and that fall mats be placed on the floor for safety. Review of Resident 4's care plan revealed a care plan focus for potential for falls with interventions that included, but were not limited to, body pillow to left and right side when in bed, dated September 20, 2025; keep bed in lowest position, dated July 26, 2024; and fall mats to bilateral sides of bed requested by [representative], dated September 20, 2025. Observation of Resident 4 on September 29, 2025, at 1:30 PM, revealed that she was in bed with bilateral body pillows placed, her bed was approximately two feet off the floor, and no fall mats were present. Subsequent observations on September 30, 2025, at 10:00 AM and 12:25 PM; and on October 1, 2025, at 8:55 AM, all revealed the same findings: the Resident was in bed with bilateral body pillows placed, her bed was approximately two feet off the floor, and no fall mats were present. During a staff interview on October 1, 2025, at 11:07 AM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), observations and care plan findings were shared by the surveyor. The NHA indicated that the fall mats were not placed because the interdisciplinary team had reviewed the request by Resident 4's Representative and decided against them and, therefore, the fall mats should not have been care planned. When observation of the bed height of approximately two feet in the lowest position was discussed, the DON indicated that they were awaiting a different bed from hospice and that hospice had provided her current bed. During a staff interview with Employee 5 (Nurse Aide) on October 1, 2025, at 11:45 AM, she demonstrated that the bed was as low as it could go. She indicated that she had told administrative staff about it several times. Observation of Resident 4 on October 1, 2025, at 12:35 PM, revealed that the bilateral fall mats had been placed on both sides of her bed. Observation of Resident 4 on October 21, 2025, at 9:00 AM, revealed she was in bed with bilateral body pillows in place, her bed was approximately two feet off the floor, and the bilateral fall mats were present at both sides of her bed. During a final staff interview with the NHA and DON on October 21, 2025, at 11:17, the NHA again indicated that, although the interdisciplinary team had decided against the fall mats, staff went ahead and implemented them since they were care planned. The NHA confirmed that since they were care-planned, they should have been in place since September 20, 2025. He also confirmed that Resident 4's lowest bed height was still approximately two feet from the floor and that the falls mats could help prevent injuries should Resident 4 fall from bed again. Review of Resident 83's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 83's comprehensive care plan revealed a fall risk care plan with an intervention for Resident 83 to have a fall mat to the right side of the bed, initiated on February 7, 2025, and revised on February 8, 2025; and an intervention to keep bed in lowest position, initiated on February 14, 2024. Review of a fall incident report on Resident 83 that occurred on July 3, 2025, revealed the Resident had an unwitnessed fall in their room and was found lying on the right side of the bed, without injury. Further

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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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status for two of 19 residents reviewed (Residents 4 and 85). Findings include: Review of facility policy, titled Weighing and Measuring a Resident last reviewed May 21, 2025, read, in part, The purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. Review the resident's care plan to assess for any special needs of the resident. Review of Resident 4's clinical record revealed diagnoses that included chronic kidney disease stage 4 severe (longstanding disease of the kidneys leading to renal failure), vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), and adult failure to thrive (a past history of weight loss of more than five percent, decreased appetite, poor nutrition, and physical inactivity, often associated with dehydration, depression, immune dysfunction). Review of Resident 4's physician orders revealed the following orders: Glucerna with Carb Steady 1.5 calories 300 milliliters via feeding tube every six hours, dated September 8, 2025; a consistent carbohydrate diet with a pureed texture and thin liquids; may have pleasure foods per hospice, dated December 10, 2024; and hospice services, dated January 7, 2025. Review of Resident 4's physician order history revealed that she had an order for monthly weights until September 11, 2025. Review of Resident 4's weight documentation revealed that no weight was documented in January 2025, February 2025, April 2025, May 2025, or July 2025. Further review of Resident 4's documented weights revealed that on March 11, 2025, she weighed 225 pounds; June 1, 2025, she weighed 201 pounds; August 5, 2025, she weighed 200 pounds; and September 1, 2025, she weighed 192.4 pounds. Review of Resident 4's clinical record revealed that she had no nutritional assessments completed by the facility dietician between December 11, 2024, and September 8, 2025. Review of Resident 4's clinical record failed to reveal any documentation that Resident 4's physician, hospice provider or family were notified of her 24 pound weight loss in June 2025. Review of Resident 4's hospice nurse's visit note dated June 4, 2025, revealed that she was tolerating tube feedings and refusing to be fed orally. Pt is spitting food out. The note failed to include any documentation about the 24-pound weight loss. Review or Resident 4's hospice nurse's visit note dated June 13, 2025, revealed that she was tolerating tube feedings, but failed to include any documentation of the 24-pound weight loss. Review of Resident 4's Resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated June 18, 2025, revealed that the hospice physician documented Resident 4 was receiving Glucerna 1.5 calories 250 milliliters every six hours via her feeding tube with 120 milliliter water flushes before after feedings; that she was allowed comfort feedings with pureed diet and nectar thick liquids as tolerated. The note failed to include any notation of Resident 4's 24-pound weight loss but did include that Resident 4 no longer responds to her daughter or takes anything by mouth from her. Review of Resident 4's Resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated July 16, 2025, the hospice physician again documented the use of tube feeding for Resident 4 but failed to include any documentation of her weight loss. Review of Resident 4's Resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated August 13, 2025, the physician again documented the use of a tube feeding for Resident 4 and indicated that she no longer takes anything by mouth but failed to include any documentation of her weight loss. Review of Resident 4's progress notes revealed a note by the dietician dated September 8, 2025, at 5:57 PM, that indicated she was evaluating Resident 4 for a new onset of a pressure injury and that she was triggering for desirable significant weight loss of 32-33lb (-14.5%) over six months. The note further indicated that she had recommended changes to Resident 4's tube feeding amount, water flushes, and added vitamins to promote wound healing. During a staff interview with the Director of Nursing (DON) on October 1, 2025, at 1:30 PM, she indicated that the facility dietician does not complete nutritional assessments on residents receiving hospice services. She said that this would be deferred to hospice since she was under their services. She further indicated that the facility does not typically weigh people on hospice. During a final interview with the Nursing Home Administrator (NHA) and DON on October 21, 2025, at 1:14 PM, the DON indicated that Resident 4 was a unique case given she is under hospice services, but receiving tube feedings and remaining a full code. She confirmed that staff should have been weighing her monthly since that was the physician's order. The DON further confirmed that Resident 4's physician, hospice provider, and Representative should have been

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	395142	A. Building B. Wing	11/26/2025

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 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 facility policy review, observation, manufacturer product information, and staff interviews, it was determined that the facility failed to discard expired medications in a timely manner in one of three medication carts reviewed (Unit 2 Cart 4).Findings include: Review of facility policy, titled Medication Labeling and Storage, with a last review date of May 21, 2025, revealed, in part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Review of facility policy, titled Administering Medications, with a last review date of May 21, 2025 revealed, in part, The expiration/beyond use date on the label must be checked prior to administering. During a medication pass observation on Unit 2 on October 1, 2025, at 9:05 AM, Employee 1 was administering medications from Cart 4. Employee 1 retrieved a house stock bottle of famotidine 10 mg (milligrams) (an over-the-counter medication used to reduce stomach acid) in preparation to administer to Resident 50. Surveyor review of the bottle noted that an open date of March 4, 2025, was written on the bottle and that the manufacturer expiration date was January 2025. Employee 1 was observed confirming the medication name and dose on the bottle to Resident 50's orders, but Employee 1 failed to confirm the expiration date of the medication. During an immediate interview with Employee 1 on October 1, 2025, at 9:08 AM, she confirmed that the bottle was opened three months after the manufacturer expiration date. She also confirmed that there were no other bottles of famotidine in the cart and that staff would have been administering from this bottle. The bottle was approximately one-third full. During a staff interview with the Nursing Home Administrator and Director of Nursing on October 21, 2025, at 11:30 AM, both confirmed that the medication should not have been opened and utilized past the manufacturer expiration date. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.10(b)(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen and three of three pantry areas.Findings include: Review of facility policy, titled Policy: Storage Areas last reviewed May 21, 2025, read, in part, All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. All freezer units are always kept clean and in good working condition. Review of facility policy, titled Food from Outside Sources last reviewed May 21, 2025, read, in part, Visitors/family member will label food and beverages with the resident's name, room number, and date. Perishable foods with a 'use by' date which is 3 days from the date that it was brought into the facility.Observation of the dry storage area on September 29, 2025, at 9:27 AM, revealed one bag of spiral pasta open without an open date, and one bag of elbow pasta open without an open date. Interview with Employee 2 (Cook) on September 29, 2025, at 9:28 AM, revealed bags of pasta should be labeled with an open date once opened. Observation of the reach-in freezer 1 in the main kitchen on September 29, 2025, at 9:31 AM, revealed two bags of steak fries with one open and both not dated; one package of hot dogs not dated with a heavy presence of ice crystals; and one package of sausages not dated with a heavy presence of ice crystals. Observation of the reach-in freezer 2 in the main kitchen on September 29, 2025, at 9:33 AM, revealed one bag of sausage patties open and not dated. Further observation of the reach-in freezer 2 in the main kitchen on September 29, 2025, at 9:34 AM, revealed the bottom of the freezer was heavily soiled with food debris. Interview with Employee 2 on September 29, 2025, at 9:35 AM, revealed she was not aware of a formal cleaning schedule for kitchen equipment, but it is the expectation that kitchen equipment is kept clean at all times. Observation in the Unit 2 Pantry Refrigerator on September 29, 2025, at 9:39 AM, revealed two bags of food from outside sources not labeled with resident names or dates. Observation in the Unit 2 Pantry Freezer on September 29, 2025, at 9:40 AM, revealed one ice cream container spilled over without a lid; two frozen beverages from outside sources without resident names or dates; and one frozen meal from an outside source with an expiration date of August 25, 2025. Observation of the April 2025 Unit 2 Refrigerator/Freezer Temperature Log revealed the refrigerator temperature failed to be recorded on April 5. Observation in the Unit 1 Pantry Refrigerator on September 29, 2025, at 9:43 AM, revealed cream of wheat in a Styrofoam cup without a date; a bag of food labeled with a resident's name, dated August 4 that appeared rotten; and a container of wilted salad, labeled with a resident's name, not dated, with a four odor. Observation of the September 2025 Unit 1 Refrigerator/Freezer Temperature Log on September 29, 2025, at 9:44 AM, revealed temperatures failed to be recorded on September 13, 21-23; and temperatures were already filled for September 30. Observation of the August 2025 Unit 1 Refrigerator/Freezer Temperature Log revealed temperatures failed to be recorded on August 5 for the refrigerator and August 19 for both the refrigerator and the freezer. Observation in the Unit 3 Pantry Refrigerator on September 29, 2025, at 9:47 AM, revealed four containers of applesauce not dated; one can of kidney beans from an outside source open and not properly sealed; and one container of food from an outside source not labeled with a resident's name or date. Interview with the Nursing Home Administrator on October 1, 2025, at 10:40 AM, revealed his expectation that expired items are discarded, foods items are labeled and dated per facility policies, and food storage equipment is utilized in accordance with professional standards. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.6(f) Dietary 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. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that all residents had access to a call bell for assistance from staff for one of 19 residents observed (Resident 74).Findings include: Review of the facility policy titled, Answering the Call Light with last revised date of September 2022, and a last reviewed date of May 21, 2025, revealed 4. Be sure that the call light is plugged in and functioning at all times. Review of Resident 74's clinical record revealed diagnosis including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing). Review of Resident 74's comprehensive care plan reveals an ADL (Activities of daily living) care plan with an intervention for the Resident's call bell to be within reach, initiated on July 9, 2018. Observation conducted on September 30, 2025, at 12:30 PM, revealed Resident 74 was lying in bed with no call bell attached to their room or accessible to the Resident. Further observations conducted at 1:06 PM and 1:36 PM revealed Resident 74 still did not have a call bell attached or accessible to them in their room. Interview conducted with Employee 4 on September 30, 2025, at 1:51 PM, revealed that they were not sure why Resident 74 did not have a call bell, and further inspecting revealed the cord broke off. Employee 4 revealed that no one put a ticket for maintenance to look at it in their system and then left the room and returned at 1:54 PM with a new cord and plugged it in to ensure it worked. During an interview with the Nursing Home Administrator on October 1, 2025, at 11:05 AM, he revealed that he would have expected Resident 74 to have had a call bell attached to his room and accessible for the Resident to use and was unable to determine how long it was not functioning. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management