STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395168	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorkview Nursing and Rehabilitation	970 Colonial Avenue York, PA 17403

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 39 residents reviewed (Residents 7, 20, 94, and 108). Findings Include: Review of the facility's policy, titled Care Plans, Comprehensive Person-Centered, reviewed [DATE], read, The interdisciplinary team reviews and updates the care plan. Review of Resident 7's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) with hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) of the right dominant side and muscle weakness. Review of Resident 7's physician orders revealed an order for Cardiopulmonary Resuscitation dated February 19, 2026. Review of Resident 7's care plan revealed a care plan focus for Resident has an advanced directive of Do Not Resuscitate dated [DATE]. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on [DATE], at 10:41 AM, the DON confirmed that the care plan should have been revised in February 2026 when Resident 7's order was changed from Do Not Resuscitate to Full Code per Resident 7's Representative request. Further review of Resident 7's care plan revealed a care plan focus for Resident has a pressure ulcer, dated [DATE]. Further review of Resident 7's clinical record that she currently did not have a pressure ulcer. Her clinical record indicated that she had an arterial ulcer, which resolved on [DATE]. During a staff interview with the NHA and DON on [DATE], at 1:33 PM, the DON confirmed that Resident 7's care plan should have been revised when the wound resolved. Review of Resident 20's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and advanced cataracts (later stages of lens clouding that significantly impair vision and daily activities, often requiring surgical interventions for restoration of sight).An observation of Resident 20, on [DATE], at 12:50 PM, in the dining room, revealed the Resident eating her lunch meal. The observation revealed that Resident 20 was experiencing difficulties in locating her cup of lemonade and her ice cream. Resident 20 stated I don't want to drink his, referring to her neighbor at the table. Review of Resident 20's most recent vision consult, dated [DATE], revealed the presence of advanced cataracts and read, Surgery is not indicated as pt. [patient] is poor candidate.Review of Resident 20's interdisciplinary plan of care failed to include her low vision and advanced cataracts.The interdisciplinary plan of care revealed an intervention, dated [DATE], that read Wears glasses. Keep clean and in good repair.Continued observations of Resident 20 revealed her to not wear glasses.An interview with the DON on [DATE], confirmed Resident 20 no longer wears glasses and the care plan would be updated regarding the low vision. Review of Resident 94's clinical record revealed diagnoses that included diabetes (a condition where the body is unable to regulate blood glucose levels) and chronic kidney disease (gradually impaired kidney function, often without early symptoms, and can lead to serious complications like heart disease and kidney failure if untreated). Review of Resident 94's care plan revealed a focus are of: the Resident has an advanced directive of full code, with an intervention of: CPR (Cardiopulmonary Resuscitation) will be performed as needed, initiated [DATE]. Review of Resident 94's Physician Orders for Life-Sustaining Treatment (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(POLST- is a medical order that ensures a seriously ill person's treatment preferences are followed in emergencies), dated [DATE], revealed that if Resident 94 is found pulseless and not breathing, she wishes to be a DNR (Do Not Resuscitate, a medical order instructing healthcare providers not to perform CPR if a person's heart or breathing stops). Review of Resident 94's physician order revealed an order for, DNR (DO NOT RESUSCITATE), started [DATE]. An interview with the DON on [DATE], at 10:45 AM, revealed that Resident 94's care plan should have been updated to reflect her preference for DNR status. Review of Resident 108's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats), and diabetes mellitus type II (disease that occurs when your blood glucose, also called blood sugar, is too high). Review of Resident 108's care plan revealed a care plan focus for Resident has a pressure ulcer, dated [DATE]. Review of Resident 108's clinical record failed to reveal that she had a pressure ulcer. During a staff interview with the NHA and DON on [DATE], at 10:43 AM, the DON confirmed that Resident 108 had not had a pressure ulcer in quite some time and that her care plan should have been revised when the pressure ulcer resolved. 28 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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interviews, it was determined that the facility failed to follow physician orders for obtaining weights and notification of weight changes for two of 33 residents reviewed (Residents 98 and 108).Findings include: Review of Resident 98's clinical record revealed diagnoses that included chronic kidney disease (longstanding disease of the kidneys leading to renal failure) and hypertension (high blood pressure). Review of Resident 98's physician orders revealed an order for daily weights and to call with weight gain of two pounds (lbs) in 24 hours or five lbs in one week, dated January 10, 2026. Review of Resident 98's February 2026 Medication Administration Record (MAR) revealed that there was no daily weight documented on February 7, 16, 17, 21, and 23, 2026. In addition, on February 15, 2026, Resident 98 weighed 170.5 lbs, and on February 18, 2026, weighed 175.8 lbs; a weight gain of 5.3 lbs. Review of Resident 98's progress notes failed to reveal any documentation that Resident 98's physician was made aware of the weight gains. Review of Resident 98's March 2026 MAR revealed that there was no daily weight documented on March 16, 23, 27, 29, and 30, 2026. On March 13, 2026, Resident 98's weight was documented as not being obtained because shower door would not open. In addition, on March 1, 2026, Resident 98 weighed 170.6 lbs and on March 2, 2026, weighed 173 lbs; a weight gain of 2.4 lbs. On March 3, 2026, Resident 98 weighed 172 lbs and on March 4, 2026, weighed 174.2 lbs; a weight gain of 2.2 lbs. On March 17, 2026, Resident 98 weighed 170.9 lbs and on March 18, 2026, weighed 173.4 lbs; a weight gain of 2.5 lbs. Review of Resident 98's progress notes failed to reveal any documentation that Resident 98's physician was made aware of the weight gains. Review of Resident 98's April 2026 MAR revealed that there was no daily weight documented on April 5, 19, and 24, 2026. In addition, on April 7, 2026, Resident 98 weighed 170.4 lbs and on April 8, 2026 weighed 172.6 lbs; a weight gain of 2.2 lbs. On April 22, 2026, Resident 98 weighed 173.2 lbs and on April 23, 2026, weighed 177 lbs; a weight gain of 3.8 lbs. Review of Resident 98's progress notes failed to reveal any documentation that Resident 98's physician was made aware of the weight gains. Review of Resident 98's May 2026 MAR revealed that there was no daily weight documented on May 1 or 9, 2026. On May 14, 2026, Resident 98's weight was documented as not being obtained because scale was out of order. Review of Resident 98's June 2026 MAR revealed that there was no daily weight documented on June 5, 2026. In addition, on May 31, 2026, Resident 98 weighed 176 lbs and on June 1, 2026, weighed 178 lbs; a weight gain of 2 lbs. On June 2, 2026, Resident 98 weighed 178 lbs and on June 3, 2026, weighed 180 lbs; a weight gain of 2 lbs. On June 24, 2026, Resident weighed 173.6 lbs and on June 25, 2026, weighed 178 lbs; a weight gain of 4.4 lbs. Review of Resident 98's progress notes failed to reveal any documentation that Resident 98's physician was made aware of the weight gains. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 25, 2026, at 1:27 PM, the DON confirmed that she would expect a resident's weight to be obtained as ordered and all appropriate follow-up with physician be completed and documented accordingly. Review of Resident's 108's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats), and diabetes mellitus type II (disease that occurs when your blood glucose, also called blood sugar, is too high). Review of Resident 108's physician orders revealed an order for daily weights and to notify physician of 4 lbs or greater weight gain dated May 1, 2025. Review of Resident 108's March 2026 MAR revealed that there was no daily weight documented on March 5, 7, 12, 15, 22, 23, 28, and 30, 2026. On March 23 and 30, 2026, documentation indicated that Resident 98's weight was not obtained because she was sleeping. No additional attempts to weigh Resident 98 were documented for these dates. Review of Resident 108's April 2026 MAR revealed that there was no daily weight documented on April 2, 4, 12, 18, 22, 23, and 27, 2026. Review of Resident 108's May 2026 MAR revealed that there was no daily weight (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented on May 1, 6, 8, 9, 10, 13, 17, 24, 25, and 28, 2026. On May 23 and 30, 2026, documentation indicated that Resident 98's weight was not obtained because she was sleeping. No additional attempts to weigh Resident 98 were documented for these dates. Review of Resident 108's June 2026 MAR revealed that there was no daily weight documented on June 17 and 21, 2026. On June 17, 2026, documentation indicated that Resident 98's weight was not obtained because she was sleeping. No additional attempts to weigh Resident 98 were documented for that date. During a staff interview with the NHA and DON on June 26, 2026, at 10:43 AM, the DON confirmed that she would expect a resident's weight to be obtained as ordered. 28 Pa. Code 201.18 Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observations, and staff interview, it was determined that the facility failed to ensure a resident with limited range of motion received appropriate services, equipment, and assistance to increase range of motion and/or prevent further decrease in range of motion for one of one residents reviewed (Resident 7).Findings include: Review of facility policy, titled Restorative Nursing Services dated July 2017, indicated, in part, Residents will restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course or stay pr when discharged from rehabilitative care. Review of Resident 7's clinical record revealed diagnoses that included muscle weakness and contractures (condition of shortening and hardening of muscles, tendons, or other tissue often leading to deformity and rigidity of joints) of the right and left hand. Observations of Resident 7 on June 23, 2026, at 10:40 AM; June 24, 2026, at 12:58 PM; June 25, 2026, at 9:44 AM and 1:15 PM, revealed bilateral hand splints in a basin near her bedside. Review of Resident 7's physician orders revealed an order for bilateral hand/wrist splint check skin every shift, dated September 7, 2025. Further review of orders failed to reveal an order for a wearing schedule of the splints. Review of Resident 7's care plan revealed a care plan focus for Requires assistance/potential to restore to maximum level of function for Mobility, dated March 28, 2025, but there were no interventions regarding splinting programs. Review of Resident 7's clinical record revealed that she had received Occupational Therapy (OT) from March 23, 2026, through April 29, 2026. Review of Resident 7's Occupational Therapy Discharge summary dated [DATE], indicated in the section titled Short-Term Goals that Resident 7 was able to tolerate wearing bilateral resting hand splints for six hours daily. In addition, the section titled Discharge Recommendations, indicated that staff were educated on donning and doffing splints and completing skin checks; that Resident 7 had an order for hand splints; and that a Restorative Splint and Brace Program was established for bilateral resting hand splints daily. Review of the Restorative Education Form provided by the facility for Resident 7's splint program revealed that one Licensed Practical Nurse and two nurse aides were educated that the goal was for Resident 7 to wear her bilateral resting hand splints daily up to eight hours a day. Additionally, staff were to provide passive range of motion to fingers, wrists, and elbows flex and extend prior to donning splints because Resident 7 was totally dependent on staff for splint donning/doffing and hygiene. Review of Resident 7's clinical record to include the Treatment Administration Records and Nurse Aide Task Documentation failed to reveal any documentation of Resident 7 wearing her bilateral resting hand splints; however, it was noted that nurses were completing the ordered bilateral hand/wrist splint skin check every shift. During an interview with the Nursing Home Administrator and Director of Nursing (DON) on June 25, 2026, at 1:33 PM, the DON confirmed that there was no order indicating Resident 7's splint wearing schedule and that there was no documentation to provide that Resident 7's splints were applied. She also confirmed that she would expect the restorative program to be initiated in April 2026 when OT discharged her from services. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on facility policy reviews, clinical record review, and staff interviews, it was determined that the facility failed to provide appropriate care and services to residents receiving tube feedings for one of one resident reviewed (Resident 7).Findings include: Review of facility policy, titled Gastrostomy [G-tube: a flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition to be placed directly into the stomach]/Jejunostomy [J-tube: a flexible feeding tube placed through the abdominal wall and into the small intestine which allows nutrition to be placed directly into the small intestine bypassing the stomach] Site Care, dated October 2011, revealed, in part, Verify that there is a physician's order for this procedure. The person completing this procedure should record the following information in the resident's medical record: date and time procedure was performed; the name and title of the individual who performed the procedure; how the resident tolerated the procedure; if the resident refused the procedure, the reason why and intervention taken; and the signature and title of the person recording the data. Review of facility policy, titled Enteral Tube Feeding via Continuous Pump, dated November 2018, revealed, in part, Verify placement of tube. If anything suggests improper tube positioning, do not administer feeding or medication. Notify the charge nurse or physician. The person performing this procedure should record the following information: date and time the procedure was performed; verification of tube placement; amount and type of enteral feeding; the average fluid intake per day; the name and title of the individual(s) who performed the procedure; all assessment date obtained during the procedure; how the resident tolerated the procedure; if the resident refused the procedure, the reason why and intervention taken; and the signature and title of the person recording the data. Review of Resident 7's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) with hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) of the right dominant side, and dysphagia (difficulty swallowing) of the oropharyngeal phase (initiating a swallow). Review of Resident 7's clinical record revealed the following orders: NPO (nothing by mouth), dated August 6, 2025; enteral feeding every shift for dysphagia Jevity 1.5 at 95ml (milliliter) per hour until 1200 ml infused with 30 ml of free water flush every hour while feeding administered with start time of 10:00 PM, dated January 26, 2026; flush feeding tube with 150 ml of water every four hours dated August 6, 2025; enteral feed every day shift record the total volume infused, dated January 26, 2026; enteral feeding check for residual every shift and if over 100 ml hold feeding and notify physician, dated August 6, 2025; and oral care every six hours for NPO status, dated August 6, 2025. Further review of orders failed to reveal an order for gastrostomy tube placement verification prior to starting enteral feeding or site care to be completed every shift. Review of Resident 7's care plan revealed a care plan focus for Resident requires a tube feeding related to dysphagia to meet all nutrition and hydration needs, dated March 26, 2025. Interventions included but were not limited to g-tube care every shift dated March 26, 2025; and provide local care to G-tube site as ordered dated January 12, 2026. Review of Resident 7's Medication and Treatment Administration Records from August 2025, through June 2026, failed to reveal any documentation that G-tube site care was administered every shift or that residual feeding was checked and amount noted. In addition, it was noted that the ordered every four hour water flushes were not always documented that Resident 7 received a total of 150 mls of water; and there were two different areas for nursing staff to document amount of feeding infused and the amount infused did not consistently match ordered amount, nor did the two entries consistently match each other. During a staff interview with Employee 5 (Registered Dietician) on June 25, 2026, at 11:30 AM, Employee 5 indicated that she has not referred to Resident 7's Medication Administration Records to see what tube feeding amounts or water flush amounts were administered when assessing Resident 7's nutritional status. She said that she only read Resident 7's nurses' progress notes, which (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated that Resident 7 was receiving her feeding and tolerating it. She further said that if she had looked at the administration records, she would have seen the documentation concerns. Review of Resident 7's clinical record nursing progress notes revealed multiple notes, which indicated that Resident 7's tube placement was confirmed by air auscultation, tube feeding infusing without difficulty, no residual noted, and G-tube site without signs or symptoms of infection; however, there was not a note noted for every shift of every day. During a staff interview with the Nursing Home Administrator and the Director of Nursing (DON) on June 26, 2025, at 1:00 PM, the DON confirmed that g-tube site care and residual checks should be completed every shift and documented in the clinical record. She indicated that she would expect all documentation of Resident 7's enteral feedings and water flushes to be a true and accurate reflection of what she received in accordance with the physician's order or additional documentation as to why the ordered amounts of enteral feeding or water flushes were not administered. 28 Pa. Code 201.18 Management.28 Pa. Code 211.10 (c)(d)Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed (Resident 108).Findings Include: Review of facility policy, titled End-Stage Renal Disease, Care of a Resident with with a revision date of September 2010 revealed, in part, 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: b. how information will be exchanged between the facilities. Review of Resident's 108's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats), and diabetes mellitus type II (disease that occurs when your blood glucose, also called blood sugar, is too high). Review of Resident 108's physician orders revealed the following orders for dialysis treatments three times a week on Monday/Wednesday/Friday, dated May 8, 2025. Review of Resident 108's care plan revealed a care plan focus for dialysis with interventions that included keep open communication with dialysis center, dated April 29, 2025. Review of Resident 108's dialysis treatment communication sheets revealed the following dialysis communication sheets were missing: March 16, 20, 23, 25, and 27, 2026;April 15, 17, 20, 24, 27, and 29, 2026;May 4, 8, 18, and 22, 2026; andJune 1, 10, 19, and 22, 2026. Review of Resident 108's Medication Administration Records for March, April, May, and June (2026) revealed that she went to dialysis on the aforementioned dates. During a staff interview with the Nursing Home Administrator and the Director of Nursing (DON) on June 26, 2025, at 12:44 PM, the DON confirmed that dialysis communication sheets for the aforementioned dates were not present in Resident 108's clinical record and that dialysis consult sheets should be completed with each dialysis treatment and kept in the clinical record. She further indicated that she had contacted the dialysis center and they would be faxing over the missing communication sheets. 28 Pa Code 211.5(f) Medical records.28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of select document review, resident and staff interviews, observation, and completion of one meal test tray, it was determined that the facility failed to provide foods that are palatable and at appetizing temperatures.Findings include: Interview with Resident 91 on June 23, 2026, at 11:49 AM, revealed meals are not served hot. Interview with Resident 103 on June 23, 2026, at 10:14 AM, revealed the hot food is cold, and no condiments are served with sandwiches. Interview with Resident 108 on June 23, 2026, at 11:15 AM, revealed she did not like the food at the facility because it did not taste good. Interview with Resident 157 on June 23, 2026, at 12:29 PM, revealed the Resident doesn't like the taste of the food and doesn't get enough to eat. During tray line observation, at 12:05 PM, one pan of Chicken [NAME] was pulled from the warmer and placed in a hot well on the tray line. At that time the food temperature was 155 degrees. Interview with Employee 6 (Food Service Director) at that time revealed that one of the bays on the plate warmer wasn't functioning. A test tray completed on June 24, 2026, revealed adequate portions size, and the food was palatable for taste and texture for a regular diet; however, the temperature of the chicken alfredo with noodles, Italian blend vegetable and mandarin oranges weren't palatable for temperature. The test tray was placed on a meal cart and delivered to the 700-unit with other trays being delivered at that time; 18 minutes had elapsed between the time the test tray was prepared from the service line and presented for evaluation. Employee 6 took temperatures of the food items at the time the test tray was served for evaluation, at 12:31 PM. The following were the recorded highest temperatures: Chicken [NAME] with Noodles- 139 degrees FItalian Blend Vegetables- 135 degrees FMandarin Oranges - 58 degrees F (per Employee 6 the Mandarin oranges were to be served cold)coffee - 135 degrees Fmilk - 46 degrees F At the time of the test tray evaluation the plate was barely warm to the touch. Interview with Employee 6 at the time of the test tray evaluation revealed the food temperatures should be sufficient; as the hot food was within the standard on the facility test tray evaluation form. Interview with the Nursing Home Administrator on June 26, 2026, at 11:00 AM, revealed food temperatures were within parameters of the facility test tray evaluation form. It was also revealed there is a current work order, waiting approval, to fix the plate warmer. 28 Pa. Code 201.14(a) - Responsibility of licensee28 Pa code 211.6 - Dietary Services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, facility documents, observations, and resident and staff interviews, it was determined there is greater than 14 hours between the evening meal and breakfast the following day. The facility failed to provide and offer a nourishing snack (food from the basic food groups, either singly or in combination with each other) outside of the scheduled meal service times in accordance with resident's needs and agreement from the resident group.Findings include: Review of facility policy, titled Food and Nutrition Services, not date marked, read, in part, nourishing snacks are available to the residents. Residents may request snacks as desired, or snacks may be scheduled between meals to accommodate the residents' typical eating patterns. All residents are offered a nourishing evening snack. Review of facility provided document Meal Cart Delivery Times form, not dated, read, in part, A-wing is the first cart served at dinner between 4:15 PM and 4:25 PM and the last cart served is C-wing between 6:20 PM and 6:25 PM. The first unit served breakfast is A-wing between 7:15 AM and 7:25 AM and the last cart served is C-wing between 9:15 AM and 9:20 AM. A time span of 15 hours between dinner and breakfast. Review of facility provided document Unit Snack par level sheet documented the following snacks are stocked on each unit (par level amount/amount stocked): fudge cookies (3), oatmeal cookies (3), lemon cookies (3), potato chips (3), pretzels (3), peanut butter crackers (4), chocolate chip cookies (3), graham crackers (6), saltines (10), and animal crackers(4). Observations on June 23, 2026, between 9:45 AM and 10:15 AM, in the following nourishment pantries/nursing units, revealed: subacute, B and C wing, F east and west wing, and [NAME] II wing the snack bins contained graham crackers and cookies, and no observed peanut butter crackers or nourishing snacks in the refrigerators. Interview on June 23, 2026, at 10:00 PM, with Employee 6 (Food Service Director) revealed snacks are delivered to the nursing units daily, and sandwich(es) are stored in the Registered Nurse Supervisor refrigerator in the event there is a new admission that arrives after dinner or per resident request. Observations in the medication storage room refrigerators on June 24, 2026, at 2:00 PM, in B and C wing, and at 2:15 PM in subacute; and on June 25, 2026, at 10:50 AM in A wing, and at 10:55 AM in [NAME] 2; revealed there were no nourishing snacks observed. Observation in the Registered Nurse (RN) Supervisor office refrigerator on June 26, 2026, at 9:00 AM, no sandwiches were observed. At that time, interview with Employee 11 (RN Supervisor) it was revealed that sandwiches are stored in the nursing refrigerators on individual nursing units. During resident group meeting on June 24, 2026, at 11:30 AM, Residents 116, 141, 186, 189, and 205 indicated that they do not get offered bedtime snacks and that when they ask for them, they are told none are available. Review of Resident 91's clinical record documented diagnoses that included history of gastric sleeve surgery. Interview with Resident 91 on June 23, 2026, at 11:49 AM, revealed she had gastric sleeve surgery (a minimally invasive weight-loss procedure). She eats small meals, and she is hungry between meals and at night. She does ask staff for snacks and is told they don't have any. Review of Resident 91's physician orders included a regular diet, starting date January 14, 2026. Review of Resident 91's meal intake documentation May 27th, 2026, through June 25th, 2026, revealed 25 to 75% intake. Review of physician note dated March 3, 2026, read, in part, Resident was seen for acute visit per staff and the Resident's request. She reportedly has been complaining of increased episodes of nausea and reportedly has a poor oral intake. Resident with a history of remote gastric bypass surgery and gastrointestinal complaints in the past. Current medication list was reviewed and there has been no recent addition to her medications. Increased gastrointestinal complaints and nausea reported by the Resident during March 2026 visit. Medication timing was adjusted along with the discontinuation of her as needed Percocet (opioid used to treat moderate to severe pain), aspirin, and losartan (medication used to treat high blood pressure). In addition, a Proton (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pump Inhibitor (medication that decreases stomach acid). The surveyor requested Resident 91's tray tickets for June 23, 2026, breakfast, lunch and dinner, via email to the Nursing Home Administrator (NHA) on June 26, 2026, at 9:00 AM. The Surveyor was provided tray tickets for the dinner meal June 26th and 27th, 2026, which documented Resident 91 would be provided a ham sandwich and a peanut butter and jelly sandwich. Review of Meal Cart Delivery Form, dinner is delivered to the F east unit between 4:50 PM to 5:00 PM; therefore, Resident 91 would receive her requested evening snack with her dinner meal. Interview with Resident 157 on June 23, 2026, at 12:29 PM, revealed he doesn't like the taste of the food and doesn't get enough to eat. When he asks for a snack, he is usually told they don't have any. Email communication from the NHA on June 24, 2026, at 2:38 PM, in response to the group meeting concern, that snacks are not offered at bed time and that when they ask for a snack are told none are available, it was revealed that snacks are delivered to the units every other day or as needed. Interview with the NHA on June 26, 2026, at 11:15 AM, revealed snacks are purchased and delivered to the units on evening shift, and staff do call to requested additional snacks as needed. It was also revealed that sandwiches are stored in the RN supervisor office refrigerator. 28 Pa. Code 201.14(a) - Responsibility of licensee28 Pa code 211.6 - Dietary 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety for three of five pantry refrigerators (subacute, F- east, and [NAME] II) and lack of hand hygiene during the Lunch meal on June 24, 2026.Findings include: Review of facility policy, titled Food Storage, revised February 15, 2020, read, in part, food storage areas shall be clean at all times, house supplements will be dated at the time of receiving and again on thawing. Unserved leftovers shall be labeled, dated, and stored for a period not to exceed three days. Review of facility policy, titled Bare Hand Contact with Food and use of Plastic Gloves, revised July 2023, red, in part, plastic gloves will be worn when handling food directly with hands. Staff will utilize good hygiene practices and techniques. Gloved hands are considered a food contact surface that can get contaminated or soiled and must be changed after touching your face or a contaminated surface. Single use gloves should be discarded when soiled. Hands are to be washed when donning and doffing plastic gloves. Review of facility policy, titled Food from Outside sources, not dated, read, in part, visitors/family member will label food and beverages with the resident's name, room number and date that is was [NAME] into the facility. Observation in the Subacute nourishment pantry on June 23, 2026, at 9:47 AM, in the freezer was a half- eaten strawberry milk shake and fruit yogurt bowl, not date marked or marked with a resident identifier. In the refrigerator, there was one 32 oz container honey thick milk, open with contents partially removed not date marked with an open or use by date. Interview at that time with Employee 6 (Food Service Director) revealed resident items should be marked with a resident identifier and date marked. Observation in the F-east and west nourishment pantry on June 23, 2026, at 9:55 AM, revealed two bowls of apple sauce weren't date marked, and there was a clear liquid an inch and a half deep in the left lower bin, and the bottom shelf had a dried tan liquid. Interview at that time, with Employee 6 revealed the applesauce should be marked with a date, and the refrigerator should be clean. Observation in the [NAME] II nourishment pantry on June 23, 2026, at 9:59 AM, in the refrigerator there were two -strawberry mighty shakes, thawed not marked with a pull or use by date (the product is to be used within 14 days of thawing), and one 32 oz carton med pass 2 open with contents partially removed, not marked with an open or use by date. Interview at that time with Employee 6 revealed open items should be dated with an open or use by date. It was revealed that the mighty shakes are pulled from the freezer, the case is marked with a date when pulled, and the shakes are placed on resident meal trays for consumption. Interview with the Nursing Home Administrator (NHA) on June 26, 2026, at 11:00 AM, revealed open items should be dated with an open or use by date, resident items should be marked with a resident identifier and date marked, and refrigerators should be clean. Observation during the lunch meal on June 24, 2026, at 12:00 PM, revealed Employee 7 (Dietary Aide), with a gloved hand, opened the proofing box, retrieved a hamburger roll, then touched the roll to her bare arm and closed the proof box. Employee 7 then reached into the pan of hamburgers with the same glove hand to retrieve a hamburger, placed it in the bun, and served the sandwich on the tray line, without completing hand hygiene. Additional observation at 12:12 PM, revealed Employee 8 (Dietary Aide), with a gloved hand, utilizing serving utensils to serve soup and puree items on the left end of steam table. During a break in service, the Employee was observed to pick her teeth and inside her mouth, and rubbing her nose with a gloved hand, did not change gloves or completed hand hygiene and returned to serving (touching utensils) for the soup and puree items. At that time, Employee 6 confirmed that both Employees should've changed their gloves and completed hand hygiene. Interview with the NHA on June 26, 2026, at 11:00 AM, revealed both staff members should've changed gloves and completed hand hygiene. 28 Pa code 211.6 - Dietary 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. Based on facility policy review, clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to ensure a resident's comprehensive care plan was implemented for one of 39 residents reviewed (Resident 1).Findings include: Review of the facility's policy, titled Care Plans, Comprehensive Person Centered, reviewed January 2026, read, in part, The interdisciplinary team [IDT], in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Review of Resident 1's clinical record revealed diagnoses that included Alzheimer's Dementia with late onset (an irreversible, progressive decline in mental abilities severe enough to interfere with daily life), persistent atrial fibrillation (an irregular and often very rapid heart rhythm), intracardiac thrombosis (a blood clot that forms in one of the four chambers of the heart), and long term (current) use of anticoagulants (a substance that prevents or slows down the blood's ability to clot). Review of the Minimum Data Set (MDS- periodic assessment tool) dated June 5, 2026, revealed that Resident 1 was on anticoagulant medication. Review of Resident 1's physician orders revealed an order for Eliquis (anticoagulant) 5 mg twice a day related to atrial fibrillation. Review of Resident 1's care plan failed to include a focus area for the use of an anticoagulant medication or monitoring for bleeding. During a staff interview with Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 26, 2026, at 10:35 AM, the DON revealed that care plan input comes from the Interdisciplinary Care Team, Unit nurse, DON, Therapy, and MDS Coordinator, but nursing in general is responsible for initiating and updating. During a staff interview with NHA and DON on June 26, 2026, at 12:55 PM, the NHA and DON revealed expectations for Care Plans to be up to date for monitoring resident care needs. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing service

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policy, record review, observations, and staff interview, it was determined that the facility failed ensure the resident received care, consistent with professional standards, to treat and prevent pressure ulcers by ensuring heel lifting boots were worn for one of three residents reviewed for pressure ulcers (Resident 92).Findings Include: Review of facility policy, titled Skin and Wound Management System, revised September 2022, revealed, preventative intervention will be implemented for residents identified at risk, as appropriate, for example beds, wheelchair cushions, nutrition, incontinence, therapy, etc. Review of Resident 92's clinical record revealed diagnoses that included trans ischemic attack (TIA- a temporary blockage of blood flow to the brain) and muscle weakness (weakness in the muscles not explained by any medical diagnosis). Observation of Resident 92 on June 23, 2026, at 11:03 AM, revealed Resident 92 lying in bed. At that time, Resident 92's heel offloading boots were lying on the floor beside her wheelchair. Resident 92 was not wearing heel offloading boots. Observation of Resident 92 on June 25, 2026, at 9:56 AM, revealed Resident 92 lying in bed. At that time, Resident 92's heel offloading boots were sitting in her wheelchair near the foot of her bed. Resident 92 was not wearing heel offloading boot. Review of Resident 92's physician orders revealed an order to apply bilateral heel offloading boots at all times when in bed, starting October 16, 2026. Review of Resident 92's care plan revealed a focus area of: The Resident has limited physical mobility related to TIA, with an intervention of bilateral heel offloading boots for positioning/contracture management, with a revision date of April 13, 2026. Interview with the Director of Nursing on June 26, 2026, at 10: 45 AM, that she would expect the Resident to be wearing the boots as ordered. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy review, clinical records review, observations, and staff interview, it was determined that the facility failed to ensure that the resident environment was free of accident hazards by providing bilateral fall mats for one of two Residents reviewed for falls (Resident 49).Findings include: Review of facility policy, titled Falls Management System, last revised September 2022, revealed, The care plan interventions will address those elements determined by investigation as probable causal factors that contributed to the fall. The updated plan will be reviewed and revised as indicated by the Falls Management Team at the meeting. Documentation of implementation will be in accordance with accepted standards of clinical record keeping as outlined in Federal and State regulations and industry standards of practice. Review of Resident 's clinical record revealed diagnoses that included repeated falls (two or more falls within 12 months) and hemiplegia (paralysis on one side of the body). Observation of Resident 49 on June 23, 2026, 11:24 AM, revealed the Resident 49 lying in bed. On the floor on the left side of Resident 49's bed was a singular fall mat. Observation of Resident 49 on June 26, 2026, 9:56 AM, revealed the Resident 49 lying in bed. On the floor on the left side of Resident 49's bed was a singular fall mat. Review of Resident 49's physician orders failed to reveal an order for fall mats at Resident 49's bedside. Review of Resident 49's care plan revealed a focus area of: the Resident is at risk for falls, gait/balance problems related to stroke, with an intervention of bilateral fall mats, initiated on April 30, 2024. Further review of Resident 49's care plan revealed a focus area of: the Resident has a potential for falls, with an intervention of bilateral wedges and floor mats to both sides of the bed, revised March 28, 2024. Interview of the Director of Nursing on June 26, 2026, at 10:35 AM, revealed that Resident 49 should have had bilateral fall mats on the floor at his bedside. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to properly label medications in one of six medications carts reviewed ([NAME] 2) and one medication storage room (Subacute Care); and failed to discard expired medications in one of four medication storage rooms observed (Subacute Care).Findings include: Review of facility policy, titled Medication Labeling and Storage, reviewed January 2026, revealed, in part, Multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated. Review of facility policy, titled Medication Labeling and Storage, reviewed January 2026, revealed, in part, If the facility has discontinued outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Observation of [NAME] 2 medication cart with Employee 10 (Licensed Practical Nurse) on June 25, 2026, at 11:00 AM, revealed a Humalog Kwik insulin pen belonging to Resident 141 was opened, but not dated. Employee 10 confirmed that Resident 141's Humalog insulin pen should have been dated with an open date when opened. Observation of Subacute Care medication storage room on June 24, 2026, at 2:15 PM, with Employee 9 (Registered Nurse) revealed an opened Apisol Injectable 5/0.1 ml multi-dose vial opened but not dated. During an immediate staff interview with Employee 9, Employee 9 confirmed the vial was opened and not dated. Observation of medication storage room Subacute Care unit on June 24, 2026, at 2:15 PM, with Employee 9, revealed a bottle of Vitamin D3 50 mcg with an expiration date of March 2025; a bottle of Vitamin C 500 mg with an expiration date of April 2026; a bottle of Aspirin 325 mg with an expiration date of May 2026; a bottle of Melatonin 1 mg with a best by date of April 2024; and a bottle of Melatonin 1 mg with best by date of March 2025. During an immediate interview with Employee 9, the Employee confirmed the medications were expired and properly disposed of them. During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing on June 26, 2026, at 12:5 PM, the NHA confirmed that she would expect medications to be labeled and stored properly, and that she expected medications to be discarded when expired according to policy or manufacturer guidelines. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.9(a)(1) Pharmacy services.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on review of facility policies, observations, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to provide residents with food that accommodates resident allergies, intolerances, and preferences for one of 39 residents reviewed (Resident 157).Findings include: Review of facility policy, titled Food and Nutrition Services, not date marked, read, in part, reasonable efforts will be made to accommodate resident choices and preferences. Each resident will be provided with a well-balanced diet taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct mis is provided for each resident. Review of facility policy, titled Fluid Restriction, not dated, read, in part, a fluid restriction is put in place to limit the amount of fluid that is consumed each day. In addition to beverages, foods may be considered liquids. Anything that is liquid or melts at room temperature must be counted in the allotted fluids (i.e. ice cream). Review of Resident 157's clinical record documented diagnoses that included obesity class 3 (severely over wight based on your weight relative to your height), hemiplegia (total or partial paralysis of one side of the body caused by brain or spinal cord damage) left non-dominant side, and anxiety (feelings of tension, worried thoughts). Interview with Resident 157 on June 23, 2026, at 12:29 PM, revealed he doesn't like the taste of the food and doesn't get enough to eat. Review of the menu for June 23, 2026, lunch included Vegetable soup, ham steak, green beans, corn, ice cream and beverages. Review of Resident 157's meal ticket for lunch on June 23, 2026, read: Heart Healthy Diet, 360 milliliter (ml) flid restriction, no corn; and documented the Resident was to receive vegetable soup, saltine crackers, ham steak, green beans, alternate vegetable, ice cream, milk and coffee. Observation of Resident 157's meal tray revealed he received vegetable soup, saltine cracker, ham steak, green beans and ice cream. An alternate for corn, milk, and coffee wasn't provided. At that time, Resident 157 stated to the Surveyor he would like alternate vegetable and milk to drink. The Surveyor did inform nursing staff at the time of Resident 157's request. Resident 157's Physician orders included: heart healthy diet, start date December 4, 2025; Fluid Restriction 1500 ml total per 24 hrs. as follows: Dietary Department: 1080 ml on meal trays (breakfast 360 ml, lunch 360 ml, dinner 360 ml), Nursing Department: 420 ml (Day shift 180 ml, Evening shift 150 ml, Night sift 90 ml), start date December 4, 2025. Interview with Employee 5 (Registered Dietitian) on June 26, 2026, at 12:00 PM, revealed Resident 157 should've received an alternate item for the corn. She also stated that she would speak with Resident 157 regarding his fluid restriction and obtain his preferences for fluids when the menu is above the physician ordered allotted amount for a particular meal. During an interview with Nursing Home Administrator (NHA) on June 26, 2026, at 12:45 PM, the NHA was informed of the concern with Resident 157 not receiving an alternate vegetable in place of the corn, and the food items on the meal tray met the Resident's fluid allotment for the meal, which did not include a beverage to drink. No further information was provided. 28 Pa. Code 201.14(a) - Responsibility of licensee28 Pa code 211.6 - Dietary Services