STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395176	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambler Extended Care Center	32 South Bethlehem Pike Ambler, PA 19002

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to ensure the call bell was accessible in the bathroom for one of 19 sampled residents. (Resident 45)Findings include: Clinical record review revealed that Resident 45 had diagnoses that included right and left above the knee amputations and osteoporosis. Review of the Minimum Data Set assessment, dated January 29, 2026, revealed Resident 45 was cognitively intact, able to communicate needs to staff, had limited range of motion in both legs, and required assistance with toileting. Review of the care plan revealed Resident 45 was at risk for falls related to above the knee amputations and required staff assistance with transfers and activities of daily living. The interventions included that staff were to provide assistance with toileting and mobility as needed, and were to encourage the resident to use the call bell for assistance. Observations on March 8, 2026, at 11:45 a.m., March 9, 2026, at 11:00 a.m., and March 10, 2026, at 9:45 a.m., revealed that the call bell in the resident's bathroom was not intact and was not accessible to the resident. In an interview on March 8, 2026, at 11:45 a.m., Resident 45 stated that it had been that way for a few weeks. In an interview on March 11, 2026, at 12:55 p.m., the Nursing Home Administrator confirmed that the call bell should have been intact and accessible to the resident. 28 PA Code 211.12(d)(1)(5) Nursing services.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of manufacturer's instructions, clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to provide adequate treatment and services for respiratory therapy for one of two sampled residents who utilized respiratory equipment. (Resident 47)Findings include: Review of the facility policy entitled, Nebulizer Administration Policy, last reviewed February 6, 2026, revealed that when administering aerosolized medication via the tracheobronchial tree (a branching network of airways in the respiratory system that carries air from the environment to the lungs for gas exchange) using a nebulizer (a medical device that converts liquid medication into a fine mist for inhalation), prescribed medications were to be placed in the nebulizer cup for delivery of medication and only sterile solutions would be used. A review of Drive Power Neb Ultra Compressor Nebulizer manufacturer's instructions for model number 18080 revealed that the machine was supposed to be used for the administration of prescribed medications. Clinical record review revealed that Resident 47 had diagnoses that included chronic obstructive pulmonary disease (COPD) and a history of a coronavirus disease 2019, and was a daily cigarette smoker. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was alert and oriented and that she utilized oxygen therapy. A physician's order dated March 3, 2024, directed staff to administer a medication that relaxes muscles in the airway to increase airflow to the lungs (ipratropium-albuterol solution) four times a day, as needed, for shortness of breath or wheezing via a nebulizer. A physician's order dated November 25, 2025, directed staff to assess Resident 47 for shortness of breath when lying flat on every shift. A review of the care plan identified that Resident 47 was at risk for respiratory complications due to altered pulmonary status and COPD and included administration of respiratory treatments as ordered. Staff were to assess the resident before and after each treatment. A review of Resident 47's Medication Administration Records from February 9, 2026, through March 9, 2026, revealed that staff documented the resident was short of breath while lying flat on day shift (7:00 a.m. to 7:00 p.m.) and night shift (7:00 p.m. to 7:00 a.m.) on March 7, 2026, and on day shift on March 8, 2026. There was no evidence that staff administered the as needed nebulizer medication for the shortness of breath at those times. Observation on March 8, 2026, at 2:45 p.m., revealed that the resident was lying in bed with a nebulizer mask on her face. An aerosolized mist was observed coming from the mask, and the sound of the compressor nebulizer running was heard. In an interview on March 10, 2025, at 2:30 p.m., Resident 47 stated that she felt short of breath after her cigarette breaks, used water from her drinking cup in the nebulizer, and was not aware of the health risks of using water in her nebulizer. She was not aware that nebulizer medication was available to her and she would have preferred to have the medication. In an interview on March 10, 2025, at 2:20 p.m., the Administrator confirmed that staff did not administer a nebulizer medication to the resident, and that Resident 47 poured her drinking water into her nebulizer cup and administered it to herself. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of facility documentation, and staff interview, it was determined that the facility failed to maintain accurate reconciliation records for controlled substances on one of four medication carts. ([NAME] front cart)Findings include: Review of the facility policy entitled, Inventory Control of Controlled Substances, last reviewed February 6, 2026, revealed that the incoming and outgoing nurses were to count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift and or at least once daily and were to document the results on a Controlled Substance Count Verification/Shift Count Sheet. Review of the controlled substance logs entitled, Shift Verification of Controlled Substances Count, for January, February. and March 2026, for the front [NAME] front medication cart revealed the following: There was no documented evidence that the controlled substances were counted on two of 20 days from February 1 through 28, 2026. There was no documented evidence that the controlled substances were counted on one of nine days from March 1 through 9, 2026. In an interview on March 9, 2026, at 11:40 a.m., the Director of Nursing confirmed that there was no evidence that the controlled substances were counted and signed off on the identified dates as per facility policy and should have been. 28 Pa. Code 211.9(j.1)(5) Pharmacy services. 28 Pa Code 211.12(d)(1)(5) Nursing services.