STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395177	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose City Nursing and Rehab at Lancaster	425 North Duke Street Lancaster, PA 17602

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, facility record review, as well as resident and staff interviews, it was determined the facility failed to ensure resident smoking materials were stored securely and monitored for four residents (Residents 18, 74, 92, 93) on two units, posing a risk for fire, resulting in immediate jeopardy to the residents (first and third floor units).Findings include:Interview with the Nursing Home Administrator (NHA) during the entrance conference on May 17, 2026, at approximately 10:30 a.m., revealed the facility is a non-smoking facility and have no smoking policy. Further interview with the NHA revealed there were four residents in the building who were permitted to smoke if they had a physician's order allowing them to leave the facility unaccompanied. Continued interview with Nursing Home Administrator revealed, the four residents were assessed for smoking which demonstrated each could independently use smoking materials safely, and they signed a smoking agreement that stipulated the resident agreed to keep smoking materials in a locked box provided by the facility. The resident was allowed to keep the key, and a nursing supervisor would have a copy of the key. Observation of Resident 4 on May 18, 2026, at approximately 1:00 p.m. revealed Resident 4 ambulating on the first-floor unit, although Resident 4 resides on the second-floor unit. Review of Resident 4's May 2026 quarterly Minimum Data Set (mandatory assessment of resident needs and condition) revealed resident is cognitively impaired and ambulates independently throughout the nursing units. Interview and observation with Resident 18 on May 19. 2026 at approximately 10:45 a.m. revealed the resident resides on the fourth floor and keeps smoking materials in a compartment on her walker. Observation conducted of Resident 18 revealed the walker's compartment does not have a locking mechanism and smoking paraphernalia which includes cigarettes and lighter could easily be accessed. Interview and observation of Resident 74 on May 19. 2026 at approximately 10:50 a.m. revealed the resident resides on the fourth floor and the smoking materials were stored in an unlocked drawer at the resident's bedside. Observation of Resident 92 on May 19, 2026, at approximately 10:50 a.m. revealed that the resident resides on the fourth floor and the smoking materials were kept on top of his dresser. Smoking material would be in plain view of anyone walking by the resident's room. Interview and observation of Resident 93 on May 19. 2026 at approximately 10:50 revealed the resident resides on the first floor and the resident has a lock box for storing her smoking materials but stated I don't use it. I know I should. Resident 93 opened her hand to reveal one cigarette and lighter. Review of Resident 18's clinical record revealed resident had a smoking assessment completed on May 12, 2026, to verify the resident was safe to smoke. Review of Resident 18's care plan revealed that resident was care planned to be allowed to smoke. Review of Resident 18, clinical record revealed that Resident 18 had a physician's order dated November 12, 2025, allowing the resident to leave the facility by herself. Review of clinical record for Resident 74 revealed that Resident 74 had a smoking assessment completed on May 12, 2026, to verify that the resident was safe to smoke. Review of Resident 74's care plan revealed that resident was care planned to be allowed to smoke. Review of Resident 74, clinical record revealed that Resident 74 had a physician's order dated October 31, 2025, allowing the resident to leave the facility by himself. Review of clinical record for Resident 92 revealed that Resident 92 had a smoking assessment (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based upon review of facility policy and procedure, observation, and clinical record review, it was determined the facility failed to ensure enhanced barrier precautions were in place for residents requiring enhanced barrier precautions for 2 of 22 (Resident 13 and Resident 14) residents reviewed and failed to practice infection control prevention and mangement during tracheostomy (A surgical procedure that creates an opening through the neck directly into the windpipe) care and Gastrostomy tube (GT- A medical device inserted directly through the abdomen into stomach) care. For one of 22 residents reviewed (Resident 5). Findings: A review of the facility policy Tracheostomy Care, undated revealed the following: Aseptic technique (A collection of medical practices and procedures that helps protect patients from dangerous germs) must be used: during cleaning and sterilization of reusable tracheostomy tubes; during all dressing changes until tracheostomy wound healed; and during tracheostomy tube changes, either reusable or disposable. Sterile gloves must be used during aseptic procedures. The same policy revealed perform hand hygiene before the procedure, after removing old dressing, after removing the old cannula, after placing a new cannula, after cleaning the stoma and surrounding site. Review of facility policy, Enhanced Barrier Precautions, reviewed December 2024, indicated that enhanced barrier precautions (EBP) apply when a resident is infected or colonized CDC- targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. Personal protective equipment and alcohol-based hand rub are readily accessible to staff. A review of Resident 5's physician order revealed the following: Tracheostomy care every shift for infection prevention and Cleanse GT with normal saline solution, apply Zinc Oxide (barrier cream), apply Calcium Alginate (Are absorbent, non-adhesive dressings made from seaweed fibers used to mane moderately to heavy exuding wounds), cover with split gauze two times a day. A tracheostomy and GT care observation for Resident 5 was conducted on May 19, 2026, at 2:15 p.m., with licensed nurse Employee E7, the following were observed: Employee E7 put on mask, gown, and gloves (clean) then proceeded to the resident's bedside where tracheostomy and GT care supplies were already prepared. Employee E7 took a white towel from the cabinet and went to the bathroom to wet it. Upon returning, Employee E7 removed the resident's old necktie and old dressing then cleansed the back of the neck with the wet towel. Employee E7 took off their used gloves and put on a new clean glove without performing hand hygiene. Employee E7 removed the old cannula, discarded it and without changing their gloves proceeded in opening the sterile package of cannula then placed it to the resident's tracheostomy. Employee E7 took off their glove, applied a new clean glove then suctioned the resident. Employee E7 took off their glove, applied a new clean glove then applied a sterile slit gauze below tracheostomy, placed the tracheostomy collar back then discarded all used tracheostomy supplies. Employee E7 removed used gloves, without performing hand hygiene applied a new clean glove then proceeded into cleaning the resident's GT with normal saline with gauze, placed the ointment on their gloved fingertip then applied it into the GT's surrounding area, then applied the calcium alginate then covered with gauze. Employee E7 completed both tracheostomy and GT care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without performing hand hygiene before starting the procedure and in between procedures. An interview was conducted with Employee E7 on May 17, 2026, at 2:30 p.m. Employee E7 acknowledged that hand hygiene was not performed during the tracheostomy and GT care. The above was conveyed with the Director of Nursing on May 20, 2026, at 10:00 a.m. The facility failed to ensure infection control prevention and management were implemented during tracheostomy and GT care procedures. Review of Resident 14 quarterly MDS (Minimum Data Set - periodic assessment of resident needs) dated March 10, 2026, revealed under section M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, that the resident was marked as having two stage 3 pressure ulcers. Observation of Resident 14's room on May 17, 2026, at 9:50am; May 18, 2026, at 12:10 pm and May 19, 2026, 9:51 am revealed no signage indicating EBP was in place and no personal protective equipment available in or outside Resident 14's room. Interview with licensed staff Employee E10 on May 19, 2026, at 9:47 a.m. confirmed that Resident 14 should have EBP signage outside of room. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, it was determined that the facility failed to ensure staff were provided with a safe, functional, sanitary, and comfortable environment for three of the three medication rooms observed (Second, Third, and Fourth Medication Rooms). Findings: An observation of the Second-Floor medication room was conducted on May 18, 2026, at 9:20 a.m., in the presence of licensed nurse Employee E9. The observation revealed the following: The medication refrigerator's bottom shelves were covered with a dry brown substance. Further observation revealed a black substance on the edges of the washing sink. Employee E9 acknowledged that the medication refrigerator and washing sink were dirty and required cleaning. An observation of the Third-Floor medication room was conducted on May 18, 2026, at 9:51 a.m., in the presence of licensed nurse Employee E10. The observation revealed empty medication refrigerator had multiple dry, dark brown substances on the top and bottom shelves. Further observation revealed a dark brown substance on the edges of the washing sink. In addition, the cabinet below the sink does not close, exposing the bottom of the sink that has used/dirty winter gloves, empty plastic bottles, and black substances on the floor. An interview with Employee E10, conducted at 9:55 a.m., revealed that they are agency staff. Employee E10 does not know what the dark brown substances on the sink were, but acknowledged that the room needs to be cleaned. An observation of the Fourth-Floor medication room was conducted on May 18, 2026, at 10:00 a.m. and revealed multiple white and orange dry substances in the washing sink. Further observations revealed broken cabinets. The above was conveyed to the Nursing Home Administrator on May 19, 2026, at 2:00 p.m. The facility failed to ensure staff were provided with a safe, functional, sanitary, and comfortable environment in the Second, Third, and Fourth Floor medication rooms. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services 28 Pa. Code 201.18(b)(1) Management

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview, it was determined that the facility failed to ensure safe, clean and homelike environment was provided for one of four units observed (Second Floor Unit). Findings:An observation conducted in Resident 5's bathroom on May 20, 2026, at 9:36 a.m., in the presence of licensed nurse Employee E7 revealed two broken tiles behind the toilet bowl exposing an approximate one foot by half foot hole on the wall.Interview with Employee E7 on May 20, 2026, at 9:40 a.m., revealed that they were not aware of the hole on the wall until shown by surveyor.The above was conveyed with the Nursing Home Administrator on May 20, 2026, at 3:00 p.m.The facility failed to ensure safe, clean and home-like environment was provided to the residents on the Second Floor Unit. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services 28 Pa. Code 201.18(b)(1) Management

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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 clinical record review and staff interviews, it was determined that the facility failed to create a comprehensive care plan with interventions for one of 22 residents reviewed (Resident 1).Findings include:Review of Resident 1's face sheet revealed medical diagnoses that included dementia (general loss of cognitive abilities, including memory).Review of the Resident 1's progress note of 3/20/2026 atv19:36 nursing note stated Resident exit seeking and getting angry at staff. Redirection and 1:1 effective. Review of Resident 1's clinical records revealed physician orders dated March 25, 2026, for Wanderguard (wearable bracelets and door sensors to track at-risk individuals, prevent them from leaving secure areas, and instantly alert caregivers if a boundary is breached) to Left Wrist A-1425-3796 every nightshift check for proper function AND every shift check for proper placement.Review of Resident 1's clinical records failed to reveal a care plan for wander guard and elopement.Interview with Director of Nursing on May 20, 2026, at 10:35 a.m. confirmed the above findings.28 Pa. Code 211.5(f) Clinical records28 Pa Code 211.11(d) Resident care plan28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review and staff interview, it was determined that the facility failed to ensure that the ordered medication to promote comfort was administered to a resident with a terminal diagnosis for one of eight residents reviewed (Resident 71). Findings: A review of Resident 71's admission progress notes dated April 3, 2026, at 4:30 p.m., revealed the resident was admitted to the facility with a recent left parietal intraparenchymal hemorrhage to CAA (Cerebral Amyloid Angiopathy- A spontaneous bleed in the outer brain tissue). The resident also had a diagnosis of cognitive impairment and seizure disorder (A chronic neurological condition characterized by recurrent seizures caused by abnormal electrical activity in the brain). The same note revealed Patient was admitted to TNU (Transitional Neurology Unit) with TACS (Trauma and Acute Care Surgery) consult for critical management. During this 12-day hospitalization, the family decided, after physician recommendation, to place [them]on end-of-life/hospice care. The same note revealed that hospice was aware, waiting for insurance information/authorization. admission assessment revealed the following: Unable to move right upper and lower extremity; Resident is awake and alert, mumbles in Spanish but was aphasic (A neurological language disorder that impairs the ability to speak, write, and understand both spoken and written language); with foley catheter (A thin, flexible tube inserted into the bladder through the urethra to collect and drain urine); and a wound to the right buttock and left hip. A review of Resident 71's physicians order dated April 3, 2026, revealed the following orders: Lorazepam (anti-anxiety medication) give 1 mg by mouth two times a day for restlessness / agitation for 10 days - terminal condition: and Morphine Sulfate (An opioid medication used for the management of severe pain) oral solution give 10mg/ml give 2.5 ml by mouth every six hours as needed for pain, discomfort, restlessness, SOB (shortness of breath), hospice/end of life. A review of the nursing progress notes dated April 3, 2026, at 5:13 p.m., revealed Writer calling the pharmacy right after faxing, re (regarding) controlled medication order (prior to 1700). [Name] at the pharmacy says they pulled them in the queue, so we can request a script from Cubex (automated medication storage). A review of the facility's emergency medication list, Inventory on Hand, revealed that both Morphine and Lorazepam were available in the facility. A review of the nursing progress notes dated April 3, 2026, at 9:50 p.m., revealed: Resident is noted to be anxious and keeps on touching the foley catheter. Due meds (medications) are given, though some are still pending for delivery. Called pharmacy to speed up the delivery. A review of Resident 71, April 2026, MAR (Medication Administration Record) revealed that residents were not administered with as-needed Lorazepam and Morphine ordered for discomfort and restlessness on the evening of April 3, 2026. A review of Resident 71's nursing progress notes dated April 4, 2026, at 7:22 p.m., revealed: Resident is noted to be anxious and keeps touching the foley catheter. Needs anticipated and due nursing care given. Monitoring continues. A review of the nursing progress notes dated April 4, 2026, at 9:09 p.m., revealed Family contacted this writer, concerned about pt (patient) pain medications. PT was provided PRN (as needed) Tylenol for pain from the nurse present and PRN for anxiety. This writer contacted the on-call pharmacist. The same notes revealed family reports they had contacted hospice, but pt is not admitted yet (to hospice). A review of the nursing progress notes dated April 4, 2026, at 22:16 p.m., revealed: Family resident requested pain medication because they think the [resident] is in pain. A review of Resident 71's MAR revealed the resident was not administered the ordered Lorazepam until the morning of April 4, 2026. MAR revealed ordered Morphine as needed for discomfort and restlessness was not administered until April 4, 2026, at 10:16 p.m., with a PAINAD (A tool used to assess pain for cognitively impaired person) pain level of 6 (moderate pain). The above was conveyed to the Director of Nursing on May 20, 2026, at 11:00 a.m. The facility failed to ensure that Resident 71's ordered medication to promote comfort for a terminal condition was followed. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain and monitor weights for two of three residents reviewed for nutrition (Resident 10 and Resident 106).Findings include: Review of facility policy, Weight Assessment and Intervention, revised March 2019, revealed that Any weight gain or loss of 5 pounds or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the Physician or Dietician. The Dietician and/or Certified Dietary Manager will review the individual weight records to follow individual weight trends over time, making recommendations as appropriate. Review of Resident 10's clinical record revealed recorded weights of 243.5 pounds on March 1, 2026; 234.4 pounds on April 3, 2026; (loss of 9.1pounds in one month). There was no re-weigh conducted to address the weight loss. Further review of Resident 10's clinical record failed to reveal recommendations to address the weight loss. Interview with Employee E4 on May 20, 2026, at 9:20 a.m. confirmed that further dietary interventions should have been implemented to address Resident 10's weight loss. Review of Resident 106's weights showed documented weights of 170.6 pounds on March 06,2026, and 161.5 pounds on April 09, 2026, reflecting a loss of 9.1 pounds in one month and three days. The clinical record did not contain evidence that staff re-weighed Resident 106 to confirm the weight loss as required by facility policy. Further review of Resident 106's clinical record showed no documented recommendations or interventions to address the weight loss. An interview with the Nursing Home Administrator (NHA) conducted on May 20, 2026, at 12:36 p.m., confirmed that Resident 106 was not re-weighed after the documented loss and no additional dietary interventions were implemented to address Resident 106's weight loss. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.10(c) Resident Care Policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Service

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on a clinical records review and interview with residents and staff, it was determined that the facility failed to ensure medication orders for dialysis residents were followed for one of two residents reviewed (Residents 11).Findings: A review of Resident 11's diagnosis list includes End Stage Renal Failure (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own), and dependence on Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally). A review of Resident 11's physician's order revealed: Dialysis every Tuesday, Thursday, Saturday (11:15am pick-up for 12pm arrival). A review of Resident 11's physician's order dated December 11, 2025, revealed an order for Calcium Acetate (A phosphate binder medication used to treat excess phosphate in the blood) 667, give two tablets three times a day. The medication was scheduled at 8:00 a.m., 12:00 noon, and 4:00 p.m. A review of Resident 11's April and May 2026, Medication Administration Record (MAR) revealed that Calcium Acetate was not administered at 12:00 noon on the following dates April 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 25, 28, 30, 2026, and May 5, 7, 9, 12, 16, and 19 2026. MAR review revealed medication was not administered due to the residents being on Leave of Absence. There was no documentation indicating that the physician was notified of missed Calcium Acetate due to the resident being out for Dialysis. The above was conveyed to the Director of Nursing (DON) on May 20, 2026, at 11:00 a.m. The facility failed to ensure Resident 11's medication order was followed. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of the facility's policy, observations, and staff interviews, it was determined that the facility failed to properly stored medications in one of three medication rooms observed (Second Floor Medication Room). Findings: A review of the facility's policy titled Medication Labeling and Storage, undated, revealed If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The same policy revealed The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. An observation of the Second-Floor medication room was conducted on May 18, 2026, at 9:20 a.m., in the presence of licensed nurse Employee E9. The observation revealed the following: The medication refrigerator's bottom shelves were covered with a dry brown substance. Further observation revealed five Insulin Glargine pens with an expiration date of February 25, 2026. An interview with Employee E9 conducted on May 18, 2026, at 9:22 a.m., revealed that 11-7 shift staff are responsible for cleaning and checking the medication refrigerator. Employee E9 was unable to provide an explanation for why outdated medications were still stored in the medication refrigerator. Employee E9 confirmed that the refrigerator was dirty and required cleaning. The above was conveyed with the Nursing Home Administrator on May 19, 2026, at 2:00 p.m. The facility failed to ensure medications were properly stored on the Second-Floor medication room storage. 28 Pa. Code 211.10(c) Resident Care Policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Service

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	395177	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose City Nursing and Rehab at Lancaster	425 North Duke Street Lancaster, PA 17602

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical records review and staff interview, it was determined that the facility failed to follow laboratory orders for two of 22 residents reviewed (Resident 3 and 109).Findings include: Review of Resident 3's quarterly minimum data set (MDS – a mandatory assessment of a resident's physical condition and care needs) dated February 26, 2026 revealed that Resident 3 was cognitively intact and had the diagnoses anxiety disorder (a group of serious mental health conditions characterized by persistent, excessive fear or worry that is out of proportion to the actual situation) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 3's medication administration record revealed physician order for Depakote (an anti-seizure medication often used to manage mood disorders) 125 MG (milligrams) twice a day for depression. A psychiatric progress note dated January 12, 2026 at 5:52 p.m. revealed: Recommend valproic acid serum level (a blood test ordered for patients taking Depakote to determine if the substance valproic acid is at optimal levels) be drawn this week and every 6 months, for monitoring related to Depakote pharmacotherapy (treatment that uses pharmaceutical drugs to address a health condition). Review of physician orders dated January 16, 2026 revealed an order for bloodwork that included Valproic acid serum level q3 (every 3) months. Review of laboratory records revealed no evidence that Valproic acid levels were obtained. Review of psychiatric progress note dated February 23, 2026 at 4:29 p.m. revealed: recommend valproic acid serum level be drawn this week and every 6 months for monitoring related to Depakote pharmacotherapy. Review of nursing progress notes dated February 24, 2026 at 4:01 p.m. revealed Psych (psychiatric provider) in for resident visit and review , with n.n.o. (no new orders) for med changes. Psych suggesting to check valproic acid level with next labs and labs q 6 months, however, request these labs routine q 3 months. Notification to be sent to psych regarding labs. Review of laboratory records revealed no evidence that Valproic acid levels were obtained. Interview with the DON and NHA on May 20, 2026 at approximately 12:30 p.m. revealed that there were no results because the bloodwork had not been obtained. A review of Resident 109's physician's order dated December 25, 2025, revealed and order for CBC (complete blood count), CMP (complete metabolic count), Vitamin b12, Vitamin D, Ferritin level every night shift every three month (s) starting on the 1st related to Myotonic Muscular Dystrophy (A genetic disorder that causes progressive muscle weakness, wasting, and inability to relax muscle). The laboratory order was scheduled for January 1, 2026, and April 1, 2026. A review of the laboratory result page revealed that there was no blood work done for April 1, 2026. A review of Resident 109's physician order dated April 14, 2026, revealed an order for CBC with differentials and CMP today. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the laboratory result page revealed that there was no blood work done for April 14, 2026. There was no documentation indicating that physicians were notified of the missed laboratory orders. An interview with the Director of Nursing was conducted on May 21, 2026, at 10:00 a.m. The DON confirmed that there was no blood work done on April 1 and 14, 2026. The DON could not provide a reason why the ordered blood work was not done. The DON confirmed that the physicians were not notified of the missed laboratory orders. The facility failed to ensure that Resident 109's blood work for April 1, 2026, and April 14, 2026, was followed. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observations, interview, and review of facility documentation, the facility failed to provide dentures to one out of seven residents reviewed (Resident 2).Findings include:Review of facility policy titled, Dental Services, revised in December 2026, revealed Routine and emergency detail services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.Interview with Resident 2 on May 18, 2026 at approximately 2:05 p.m., revealed that he had been fitted for dentures in last year. Further, he revealed that he had yet to receive any dentures and no facility staff had followed up with him about the dentures. Further interview revealed that Resident 2 felt that without any teeth he talked funny and it was difficult to eat some foods.Review of Resident 2's care plan revealed Resident 2 was care planned for oral/dental health problems r/t (related to) possible broken/carious teeth.Review of Resident 2's physician orders reveal a therapeutic (prescribed for a particular health condition), regular texture diet with thin liquids.Review of Resident 2's weight chart revealed that Resident 2 weighed 192.3 pounds in December 2025, 196.4 pounds in January 2026, 199.2 pounds in February1 2026, 197.2 pounds in March 2026, 195.8 pounds in April 2026, and 193 pounds in May 2026, reflecting no significant weight loss.Review of Resident2's dental consult sheet dated November 17, 2025 revealed a dental a note that stated: Pt (patient) wants FU/FL (full upper and full lower dentures). Has had FMX (full mouth x-rays) done and lower impressions done.Review of Resident 2's clinical chart failed to reveal any documentation of the request for dentures or the dental services provided on November 17, 2025 in the progress notes.Review of Resident 2's dental consult sheet dated December 31, 2026 revealed a form with recommendations for full upper and full lower dentures circled and that a full mouth x-ray series was performed.A review of nursing progress notes dated December 31, 2026 at 8:43 a.m. revealed: Seen by Dental Services on 12/30/25. No new orders. Recommended for full upper and lower dentures.Interview with the Nursing Home Administrator (NHA) on May 20, 2026 at approximately 11:00 a.m. confirmed that Resident 2 was fitted for dentures and the dentures were made, but the company that made the dentures claimed there was a balance due and would not release the dentures to the resident. Subsequently the dentures were not delivered to Resident 2 because of the dispute that remains ongoing. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on the review of job descriptions, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure the safety of residents when residents who smoke were permitted to keep smoking materials unsecured in their rooms and on their person. This failure resulted in an Immediate Jeopardy situation.Findings Include:Review of the job description for the Nursing Home Administrator (NHA) states position purpose is to manage the Facility in accordance with current applicable federal, state, and local guidelines, and regulations that govern long term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times.Review of the job description for the Director of Nursing (DON) states that the position is to: Plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that cover the facility and as may be directed by the Administrator and the Medical Director to ensure that the highest degree of quality care is maintained at all times.The findings in this report identified the facility failed to maintain the safety of the residents from risk of fire by ensuring that there was a system in place to monitor and account for smoking materials for the residents who were assessed to be allowed to smoke during their leaves of absence.Refer to F689 28Pa Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(b)(3) Management

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, observation, and clinical record review, it was determined that the facility failed to ensure an accurate clinical medical record for 1 of 1 resident reviewed (Resident 106). Findings include:A review of the facility policy titled Charting and Documentation, last revised July 2017, revealed the policy states, Documentation in the medical records will be objective, complete, and accurate.A review of Resident 106's diagnoses included Muscle Weakness (generalized weakness meaning overall reduced strength throughout the body).A review of Resident 106's physician order dated February 16, 2026, at 3:00 p.m., revealed an order for Weekly Skin Review on Mondays 3-11 shift. Complete Weekly Skin Review on the Tab FORMS. Document refusal every evening shift every Mon. and another physician order dated April 8, 2026, at 3:00 p.m., for Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to left buttocks topically every day and evening shift for Wound care.A review of Resident 106's April 2026 and May 2026 electronic Medication Administration Record (eMAR) revealed the Triad treatment was not administered on the following dates and shifts:April 12, 2026, day shift.April 14, 2026, evening shift.May 5, 2026, day shift.May 13, 2026, evening shift.A review of Resident 106's nursing progress notes failed to reveal any documentation explaining why the Triad was not administered on the dates listed above.A review of Resident 106's skin assessment dated [DATE], revealed no new areas of concern.A review of Resident 106's skin assessment dated [DATE], revealed, Resident seen by wound care nurse yesterday 4/07/2026, new orders for wound to left buttocks, cleanse wound with Normal saline apply Triad Hydrophilic Wound Dress External Paste to wound BID.A review of Resident 106's skin assessment dated [DATE], revealed no new areas of concern.A review of Resident 106's skin assessment dated [DATE], revealed no new areas of concern.A review of Resident 106's skin assessment dated [DATE], revealed Left buttock wound continues with treatment in place.A review of Resident 106's skin assessment dated [DATE], revealed no new areas of concern.An interview with the Nursing Home Administrator (NHA) conducted on May 20, 2026, at 12:36 p.m., confirmed the Triad treatment was incorrectly entered in Resident 106's clinical record, the skin assessment documentation present in Resident 106's clinical record belonged to a different resident, and Resident 106 does not currently have a wound.The facility failed to ensure that Resident 106's clinical medical records were complete and accurate.