STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395200	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Nursing and Rehab	4850 Zuck Road Erie, PA 16506

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of facility policy, clinical records, observations, and interviews, it was determined that the facility failed to ensure that a resident's dignity was maintained for five of 26 residents reviewed (Residents R18, R62, R89, R110, and R122). Findings include: Review of the facility policy entitled, Dignity dated 1/12/26, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times.Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: b. promptly responding to a resident's request for toileting assistance. Resident R18's Brief Interview for Mental Status (BIMs-15-point cognitive screening measure that evaluates memory and orientation and includes free and cued recall items) was 15 (cognitively intact).During an interview with Resident R18 on 5/12/26, at approximately 11:20 a.m. Resident R18 reported, When he/she asked staff to assist him/her to the restroom because he/she needed to go to the bathroom staff told him/her to just go in their pants. Resident R62's Brief Interview for Mental Status (BIMs-15-point cognitive screening measure that evaluates memory and orientation and includes free and cued recall items) was 15 (cognitively intact).During an interview with Resident R62 on 5/12/26, at approximately 8:35 a.m. Resident R62 reported, That he/she has been lying in a wet bed all night and has rung his/her call bell twice since 6:00 a.m. asking the staff to change their wet bed and the staff told him/her that they would have to wait to be changed until breakfast trays were passed. He/she has waited one to two hours for their call bell to be answered. Observations made at that time revealed that Resident R62 rang their call bell at 8:35 a.m. and it was not answered until 8:50 a.m. Resident R62 was pulling on the bottom sheet and his/her pajamas while moving around in bed. The part of the sheet that he/she had pulled out from under him/her was saturated. Resident R89's Brief Interview for Mental Status (BIMs-15-point cognitive screening measure that evaluates memory and orientation and includes free and cued recall items) was 15 (cognitively intact).During an interview with Resident R89 on 5/11/26, at approximately 1:00 p.m. Resident R89 reported, That he/she rings the call bell for assistance and waits at least one hour at times, because of sitting in wet pants he/she now has a rash. Resident R110's Brief Interview for Mental Status (BIMs-15-point cognitive screening measure that evaluates memory and orientation and includes free and cued recall items) was 15 (cognitively intact).During an interview with Resident R110 on 5/12/26, at approximately 1:08 p.m. Resident R110 reported, That he/she rings the call bell for assistance and sits for hours waiting to be changed. He/she indicated at the end of a shift if they ring for assistance and staff leaves it for the next shift and then the staff on the next shift become upset because it ends up being a full bed change. Review of Resident R122's clinical record revealed an admission date of 5/08/26, with diagnoses that included fractured left hip, sudden respiratory failure, and Type 2 Diabetes (condition when the body cannot use insulin correctly and sugar builds up in the blood). Observation on 5/13/26, at 8:20 a.m. revealed Resident R122 sitting in bed with his/her head elevated and repeatedly moaning help me. Nurse Aide (NA) Employee E7 entered Resident R122's room, replaced his/her call bell device from the floor to the bed and inquired what was wrong. Resident (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R122 replied I hurt, NA Employee E7 informed Resident R122 that he/she would tell the nurse, then NA Employee E7 exited the room. Resident R122 continued to moan loudly. At 8:28 a.m. Resident R122 continued to moan loudly and NA Employee E3 entered his/her room, retrieved Resident R122's roommate's breakfast tray from across the room and failed to respond to Resident R122's continued moaning. Continued observation between 8:28 a.m. and 8:47 a.m. revealed that neither NA Employee E3 nor E7 reported Resident R122's pain to Licensed Practical Nurse (LPN) Employee E1. Interview on 5/13/26, at 8:47 a.m. with LPN Employee E1 confirmed that he/she was not notified of Resident R122's pain, and then he/she proceeded to Resident R122's room. During an interview on 5/13/26, at 9:57 a.m. the Director of Nursing (DON) and Regional Clinical Representative confirmed that staff should have reported the pain to the nurse. An interview with the DON on 5/13/26, at 11:10 a.m. confirmed that staff should always respond to resident call bells and needs in a dignified and timely manner, and residents should never be left saturated or told to go in their pants. 28 Pa. Code 201.29(c) Resident rights28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies and documents, and staff interviews, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean environment and maintain resident equipment in good repair in two of five resident Units (Unit 2 and Unit 4).Findings include: A facility policy entitled, Quality of Care-Homelike Environment dated 1/12/26, indicated that residents are provided with a safe, clean, comfortable and homelike environment: that facility staff and management shall maximize, to the extent possible, the characteristics of the facility to reflect a personalized, homelike setting and included clean, sanitary, and orderly environment. A facility policy entitled Assistive Devices and Equipment dated 1/12/26, indicated The following factors will be addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment. Device. equipment will be maintained. A facility document provided to surveyors on 5/12/26, entitled, Housekeeping Log-Daily Resident Room and Bathroom Cleaning indicated staff would: collect trash in room and bathroom; spray bathroom cleaner to allow it to work; clean toilet; dust mop; and damp mop. Observations on 5/11/26, between 1:31 p.m. and 4:00 p.m. and on 5/12/26, between 9:00 a.m. and 9:30 a.m. revealed the following: room [ROOM NUMBER]A with the right side of the footboard on the bed hanging and resting on the floor and the bracket screws not engaged, and an accumulation of dirt in the corner of the left doorway under glove dispenser. room [ROOM NUMBER]A with a metal spoon lying on the floor between the bed frame and fall mat on the right side of the bed, and a white bottle of deodorant lying on the floor against the wall on the left side of the bed, and a pile of white dust on the floor at the top left corner of the bed. room [ROOM NUMBER]A with food particles, debris, and dried liquid stains (scuffs) on the fall mats on both sides of the bed. room [ROOM NUMBER]A with a grey foam oxygen tubing ear protector lying on the floor between the right side of the bed and the nightstand. room [ROOM NUMBER]B with a blue and green plaid neck pillow lying on the floor at the top left corner of the bed, between the bed frame and nightstand; and black streak down the left side of the toilet bowl to the base at the floor. room [ROOM NUMBER]A with a pile of white dust on the floor at the top left corner of the bed. Accumulation dark gray substance, dust, and debris, behind the open fire doors to Unit 2. During an interview on 5/12/26, between 11:00 a.m. and 12:00 p.m. the Environmental Services Supervisor confirmed the above-mentioned observations, and that housekeeping staff should have done a better job at cleaning the areas. Observations on 5/11/26, between 1:30 p.m. and 3:40 p.m. and 5/12/26, between 10:00 a.m. and 3:04 p.m. and again on 5/13/26, at 8:54 a.m. revealed the following: room [ROOM NUMBER] B bed occupied by a resident had no foot board attached to the bed. room [ROOM NUMBER] A bed occupied by a resident, the headboard was attached to the frame on one side, and the other side was hanging down. During an interview on 5/13/26, at 2:06 p.m. the Nursing Home Administrator confirmed that the B bed in room [ROOM NUMBER] was occupied and missing a foot board. He/she also confirmed that the A bed in room [ROOM NUMBER] was occupied and the headboard was attached to one side of the bed frame and the other side was hanging down. He/she also confirmed that beds should have foot boards and that headboards should be attached appropriately. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for four of seven residents reviewed (Residents R10, R18, R31, and R68).Findings include:Review of facility policy entitled Transfer or Discharge Documentation dated 1/12/26, indicated Should the resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider:The basis for the transfer or discharge;Contact information of the practitioner responsible for the care of the resident;Resident representative information including contact information;Advance Directive information;All special instructions or precautions for ongoing care, as appropriate;Comprehensive care plan goals; andAll other necessary information.Review of Resident R10's clinical record revealed an admission date of 11/18/24, with diagnoses that included muscle weakness, dysphagia (difficulty swallowing), and anemia (a blood condition where the body lacks enough healthy red blood cells or hemoglobin to carry adequate oxygen to the tissues).Review of Resident R10's progress notes revealed notes dated 11/9/25, and 4/1/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or their representative were provided with a copy of the bed-hold policy upon transfers on 11/9/25, and 4/1/26. Review of Resident R18's clinical record revealed an admission date of 7/3/25, with diagnoses that included hemiplegia and hemiparesis (a condition where a person has weakness and is paralyzed and unable to move one side of their body), hypertension (high blood pressure), and hyperlipidemia (high cholesterol).Review of Resident R18's progress notes revealed a note dated 10/1/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or their representative were provided with a copy of the bed-hold policy upon transfer on 10/1/25. Review of Resident R31's clinical record revealed an admission date of 7/3/25, with diagnoses that included chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs), hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and hypertension. Review of Resident R31s progress notes revealed notes dated 11/28/25, and 12/21/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or their representative were provided with a copy of the bed-hold policy upon transfer on 11/28/25.Review of Resident R68's clinical record revealed an admission date of 12/7/22, with diagnoses that include hemiplegia and hemiparesis, hypertension, and dementia (a disease that affects short term memory and the ability to think logically).Review of Resident R68's progress notes revealed a note dated 12/5/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider.During an interview on 5/14/26, at 9:30 a.m. the Director of Nursing confirmed that Residents R10, R18, R31, and R68's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider and lacked evidence indicating that residents and/or their representatives were provided with a copy of the bed-hold policy upon transfer.28 Pa. Code 201.18(e)(1) Management28 Pa. Code 201.29(c.3)(2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for four of 26 residents reviewed (Residents R18, R31, R101, and R122).Findings include:Review of facility policy entitled Baseline Care Plan dated 1/12/26, revealed that a written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:The initial goals of the resident. A summary of the resident's medications.Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.Review of Resident R18's clinical record revealed an admission date of 7/3/25, with diagnoses that included hemiplegia and hemiparesis (a condition where a person has weakness and is paralyzed and unable to move one side of their body), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Resident R18's clinical record revealed a re-admission evaluation dated 10/8/25. The clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R18 and/or their representative. Review of Resident R31's clinical record revealed an admission date of 7/3/25, with diagnoses that included chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs), hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and hypertension. Resident R31's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R31 and/or their representative. Review of Resident R101's clinical record revealed an admission date of 4/22/26, with diagnoses that included muscle weakness, dysphagia (difficulty swallowing), and hypertension.Resident R101's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R101's and/or their representative. Review of Resident R122's clinical record revealed an admission date of 5/08/26, with diagnoses including fractured left hip, sudden respiratory failure, and Type 2 Diabetes (body cannot use insulin correctly and sugar builds up in the blood).Resident R122's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R122 and/or their representative.During an interview on 5/13/26, at 12:50 p.m. the Director of Nursing confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Residents R18, R31, R101, and R122 and/or their representatives.28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of a facility policy, observations, and staff interview, it was determined that the facility failed to maintain sanitary operations in the main kitchen and failed to ensure that food was stored in accordance with standards for food safety in the main kitchen and two resident pantries reviewed (Neighborhoods 200 and 300).Findings include: Review of facility policy entitled Food Receiving and Storage dated 1/12/26, indicated Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen or discarded. And All foods belonging to residents are labeled with the resident's name, the item and the use-by date. Review of facility policy entitled Foods Brought by Family/Visitors dated 1/12/26, indicated Containers will be labeled with the resident's name, the item and the use-by date. The facility staff will discard perishable foods on or before the use-by date. Review of facility policy entitled Sanitization dated 1/12/26, indicated The food service area is maintained in a clean and sanitary manner. and All kitchens, kitchen areas . are kept clean, free from garbage and debris. Review of the med pass supplement label revealed After open, consume product within 4 days if properly refrigerated. Observations during tour of the main kitchen on 5/11/26, at 11:40 a.m. revealed in the reach in refrigerator a submarine sandwich inside of a plastic bag and was lacking a name and date. During an interview at the time of observation with the Dietary Manager, he/she confirmed that the sandwich had no name and date and staff were unable to determine the discard date. He/she also confirmed that the sandwich should have been discarded. Observations on 5/11/26, at 12:51 p.m. of a pantry used for residents on 200-neighborhood revealed an open container of med pass (a supplement given to residents during medication administration) with an open date of 5/2/26. During an interview on 5/11/26, at the time of observations with Licensed Practical Nurse Employee E4, he/she confirmed that the med pass was dated open on 5/2/26, which was beyond its use by date and should have been discarded. Observations on 5/11/26, at 1:16 p.m. of a pantry used for residents on 300-neighborhood, revealed a red container with what appeared to be food inside and was lacking a name and date. During an interview on 5/11/26, at the time of observations with Nursing Assistant Employee E5, he/she confirmed that the red container lacked a name and date. He/she also confirmed that staff were unable to determine the discard date and the container should have been discarded. Observations on 5/11/26 between 11:40 a.m. and 2:40 p.m. in the main kitchen revealed a large amount of food crumbs, and debris under the prep tables, and steam table. A drainage grate on the floor under the sink behind the steam table revealed black and gray substances stuck to it. During an interview on 5/12/26, at 11:42 a.m. the Dietary Manager confirmed there was a large amount of food crumbs, debris under the prep tables, and steam table and the drainage grate on the floor under the sink needed cleaned. He/she also confirmed that the kitchen floors are to be cleaned daily. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on review of facility policy, clinical records, and staff and resident interviews it was determined that the facility failed to develop and implement an individualized discharge planning process that addressed residents' discharge goals and incorporated those goals into the resident's comprehensive care plan for one of 26 residents reviewed (Resident R78).Findings include: A facility policy entitled Discharge Summary and Plan dated 1/12/26, indicated that resident's transferring to another skilled nursing facility will be assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. Resident R78's clinical record revealed an admission date of 10/19/23, with diagnoses that included heart failure, right knee replacement, kidney disease, and irregular heartbeat. A care plan entitled Discharge Planning dated 10/20/23, included one intervention to evaluate care needs and potential for discharge with a goal to discharge Resident R78 to the most appropriate level of care. Review of Resident R78's clinical record revealed the most recent Social Services documentation was dated 6/12/24, regarding Resident R78's request for referral to other long-term care facilities. During an interview on 5/12/26, at 9:45 a.m. Resident R78 stated he/she requested to be transferred to two different long-term care facilities and was told he/she was on a waiting list for one but hasn't received any updates on his/her transfer status in a long time. During an interview on 5/12/26, at 1:12 p.m. Social Services Employee E2 confirmed Resident R78's clinical record lacked documentation of referral updates since 6/12/24, and that Resident R78's Discharge Planning care plan was not updated timely to include referrals and responses. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(2)(3) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 201.29(a) Resident rights28 Pa Code 211.10 (a)(c) Resident care policies

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, clinical records, and staff and resident interviews it was determined that the facility failed to review and revise a comprehensive care plan to reflect the individualized discharge planning process that addressed residents' discharge goals for one of 26 residents (Resident R78).Findings include:A facility policy entitled Care Plans, Comprehensive Person-Centered dated 1/12/26, indicated that the comprehensive, person-centered care plan will include the resident's stated preference and potential for future discharge, including his/her desire to return to the community and any referrals made to entities to support such a desire. Resident R78's clinical record revealed an admission date of 10/19/23, with diagnoses including heart failure, right knee replacement, kidney disease, and irregular heartbeat. A care plan entitled Discharge Planning dated 10/20/23, included one intervention to evaluate care needs and potential for discharge with a goal to discharge Resident R78 to the most appropriate level of care. Review of resident R78's clinical record revealed the most recent Social Services documentation was dated 6/12/24, regarding Resident R78's request for referral to other long-term care facilities. Interview on 5/12/26, at 9:45 a.m. Resident R78 stated he/she requested to be transferred to two different long-term care facilities and was told he/she was on a waiting list for one but hasn't received any updates on his/her transfer status in a long time. During an interview on 5/12/26, at 1:12 p.m. Social Services Employee E2 confirmed Resident R78's clinical record lacked documentation of referral updates since 6/12/24, and that Resident R78's Discharge Planning care plan was not updated timely to include referrals and responses. 28 Pa. Code 211.5(f) Medical records28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(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 review of clinical records, investigative reports, facility policy, and staff interviews, it was determined that the facility failed to complete thorough fall investigations for one of two residents reviewed for falls (Resident R3).Findings include: A facility policy entitled Accidents and Incidents-Investigating and Reporting dated 1/12/26, indicated to include the name(s) of witnesses and their accounts of the incident. Resident R3's clinical record revealed an admission date of 6/13/25, with diagnoses that included stroke with right-sided weakness, seizures, Bipolar disorder (also known as manic depressive illness or manic depression, is a mental health condition characterized by significant mood swings, including manic [or hypomanic] episodes and depressive episodes), dementia, and attention-deficit hyperactivity disorder. Review of an incident report dated 11/23/25, indicated that Resident R3 was found on the floor next to his/her bed upon the start of the day shift, and per staff interviews was observed 45 minutes prior in bed resting. Based on a statement made by Resident R3 at the time of the incident, he/she wanted a blanket and the heat turned on; he/she yelled for help, but no one came. Review of post-incident typed interviews revealed that Resident R3's door was shut per his/her request and there was no indication of how long his/her door was shut prior to the fall. Review of post-incident typed interviews of overnight staff (combined statement), indicated Resident R3 was last seen at 5:15 a.m. in bed with his/her eyes closed and the door was closed at that time. Review of a post-incident typed interview with a neighboring resident indicated that Resident R3 screamed all night and kept this resident awake and that between 5:00 a.m. and 6:00 a.m. he/she heard a thud coming from Resident R3's room and didn't hear anything else until first shift came in. Review of a post-incident typed interview with the day shift staff who found Resident R3 indicated he/she heard yelling and opened the door before entering the room and finding Resident R3 on the floor. The typed interview from day shift staff indicated that the door was shut per Resident R3's request but lacked documentation of how the staff knew that information. All typed interviews with staff lacked evidence of when (date and time) the statements were obtained and lacked evidence of confirmation from the interviewees on the content of the typed statements. During an interview on 5/13/25, at approximately 4:00 p.m. the Regional Clinical Representative confirmed that there was no indication of when statements were obtained, and the typed statements lacked staff signatures, or confirmation from the staff of the contents of the typed statements. During an interview on 5/14/26, at 8:02 a.m. the Director of Nursing did confirmed that the typed witness statements lacked evidence on who shut the door and when the door was shut. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. code 211.12(d)(5) Nursing services

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Walnut Creek Nursing and Rehab	4850 Zuck Road Erie, PA 16506

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 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. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for one of two residents reviewed with respiratory care (Resident R15).Findings include: A facility policy entitled Departmental (Respiratory Therapy)-Prevention of Infection dated 1/12/26, indicated to keep the oxygen cannula [thin, lightweight, and flexible tube that splits into two small prongs inserted into the nostrils, allowing oxygen or a mixture of air and oxygen to flow directly into the respiratory system] and tubing used as needed in a plastic bag when not in use. Review of Resident R15's clinical record revealed an admission date of 8/31/25, with diagnoses that included heart failure, chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and long-term respiratory failure. Review of Resident R15's current physician's orders revealed a physician's order dated 4/24/26, indicated that Resident R15 was to receive supplemental oxygen at two liters per minute through a nasal cannula as needed for shortness of breath. Review of Resident R15's vital signs records revealed that staff obtained his/her oxygen saturation percentage on 4/28/26, 5/01/26, 5/12/26, and 5/13/26 while the supplemental oxygen was being utilized. Observation on 5/11/26, at 1:37 p.m. revealed Resident R15's oxygen cannula and tubing was hanging over the oxygen concentrator (medical device that extracts oxygen from the surrounding air, filters out nitrogen, and delivers oxygen-enriched air to patients with low blood oxygen levels) and not stored in a plastic bag.Observation on 5/13/26, at 8:25 a.m. revealed Resident R15's oxygen cannula and tubing was lying over his/her unmade bed and not stored in a plastic bag. During an interview on 5/13/26, at 8:30 a.m. Nurse Aide Employee E3 confirmed that Resident R15's oxygen cannula and tubing should be stored in the plastic bag when he/she is not using it. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395200	A. Building B. Wing	05/14/2026

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interview, it was determined that the facility failed to dispose of garbage into the dumpster properly for one dumpster observed outside of the building. Findings include: Facility policy entitled Sanitization dated 1/12/26, indicated Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpster/compactors with lids. Observations on 5/11/26, at 12:00 p.m. of the garbage dumpster revealed two bags of garbage lying on the ground next to the dumpster. Observations on 5/11/26, at 2:35 p.m. with Dietary Aide Employee E6 of the garbage dumpster revealed the two bags of garbage lying on the ground next to the dumpster remained. During an interview at the time of observation Dietary Aide Employee E6 confirmed that there were two bags of garbage lying on the ground next to the dumpster. He/she also confirmed that there should not be garbage lying on the ground. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395200	A. Building B. Wing	05/14/2026

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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 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. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to have complete and accurate documentation regarding supplemental oxygen usage and wound dressing changes on two of 26 residents reviewed (Residents R15 and R101).Findings include: Review of facility policy entitled Charting and Documentation, dated 1/12/26, revealed, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record: and included the following information is to be documented in the resident medical record; medication administered, treatments or services performed: documentation in the medical record will be objective, complete, and accurate. Review of Resident R15's clinical record revealed an admission date of 8/31/25, with diagnoses that included heart failure, chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and long-term respiratory failure. Review of Resident R15's current physician's orders revealed a physician's order dated 4/24/26, that indicated Resident R15 was to receive supplemental oxygen at two liters per minute through a nasal cannula (thin, lightweight, and flexible tube that splits into two small prongs inserted into the nostrils, allowing oxygen or a mixture of air and oxygen to flow directly into the respiratory system) as needed for shortness of breath. Review of Resident R15's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026, and May 2026 lacked evidence that the supplemental oxygen was administered. Review of Resident R15's vital signs records revealed that staff obtained his/her oxygen saturation percentage on 4/28/26, 5/01/26, 5/12/26, and 5/13/26 while the supplemental oxygen was being utilized. During an interview on 5/13/26, at 11:52 a.m. Regional Clinical Representative confirmed that Resident R15's clinical record contained inconsistent documentation for oxygen, and that the use of the supplemental oxygen should have been documented in Resident R15's MAR due to oxygen being considered a medication. Review of Resident R101's clinical record revealed an admission date of 4/22/26, with diagnoses that included muscle weakness, dysphagia (difficulty swallowing), and hypertension (high blood pressure).The clinical record revealed that on 4/24/26, Resident R101's physician ordered a wound dressing change to be completed two times a day and as needed. Resident R101's TAR for May 2026, revealed two days (5/7/26 and 5/10/26) that lacked documentation indicating the wound dressing change was completed per physician orders. During an interview on 5/13/26, at 1:42 p.m. the Regional Clinical Representative confirmed that Resident R101's treatment records did not have complete documentation regarding wound dressing changes. 28 Pa. Code 211.5(f)(viii)(x) Medical records28 Pa. Code 211.12(d)(1)(5) Nursing services