

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Beaver Valley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 257 Georgetown Road Beaver Falls, PA 15010	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to conduct surveillance mapping for five of 12 months (October 2024, February 2025, April 2025, August 2025, and September 2025), failed to timely implement isolation precautions during contact tracing testing for candida auris, failed to implement universal masking and droplet precautions throughout the facility timely for one of five residents (Residents R116), report newly identified cases within 24 hours during a COVID outbreak for four residents (Resident R50, R51, R54, and R91) and two staff members (Nurse Aide, Employee E16 and NA, Employee E24)and failed to prevent cross contamination during a medication pass for one of three resident's (Resident R91).Findings: Review of the facility's Surveillance for Infections last reviewed 7/11/25, stated the Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on resident outcome and that may require transmission-based precautions and other preventative measures. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infections, the Infection Preventionist will collect data to help determine the effectiveness of such measures. Infections on an individual will be recorded daily to include detailed information and each month, information is collected and summarized. The data is analyzed to identify needs. Review of the Pennsylvania Department of Health Healthcare Facility Toolkit for Response to Candida auris (a fungus that can cause serious infections) dated May 2022, and updated June 2023, revealed C. auris can spread from one patient to another in hospitals and nursing homes. CDC recommends testing patients who may have come in contact with C. auris to see if they are carrying this fungus. This allows healthcare providers to know who is carrying the fungus and take steps to prevent it from spreading to other people. It was indicated residents require preemptive contact precautions while lab results are pending. The resident should be placed in private room, if possible. Healthcare personnel interacting with patients on Contact Precautions, or their environment, are required to wear a gown and gloves, donning their PPE upon room entry, and properly discarding before exiting (conventional capacity for PPE). Healthcare personnel should conduct diligent hand hygiene during and after contact with a C. auris positive patient or their environment; ensure alcohol-based hand rub is readily available. Disposable or dedicated patient-care equipment should be used whenever possible. Review of the facility's Coronavirus Disease (COVID-19) Testing Residents policy last reviewed 7/11/25, stated when testing residents with signs and symptoms of COVID, while test results are pending, symptomatic residents are placed on transmission-based precautions according to CDC guidance. The decision to discontinue empiric transmission based precautions for symptomatic residents can be made upon having negative results from at least one viral test. Symptomatic residents who refuse testing are placed on transmission-based precautions. (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 - Many	Review of the facility policy Handwashing/Hand Hygiene last reviewed 7/11/25, indicated that the facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors. Review of the Pennsylvania Department of Health COVID-19 Infection Control and Outbreak Response Toolkit for Long-Term Care Version 1.1 dated February 2024, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities revealed the following: During the Outbreak: COVID-19 Outbreak Management and Control Measures included: -Identify and Isolate First Case. -Identify Additional Cases and Exposures. -Exposed asymptomatic residents and HCP (health care professional) should be tested with a series of up to three viral tests. -Determine approach (contact-tracing, unit-based, facility-based). -Identify exposures because of close contact. -Test exposures immediately (but not within 24 hours of exposure) and if negative, another test at 48 hours, and if negative another test 48 hours later. -Evaluation and Monitoring of Residents It is important to assess for the following symptoms and implement prompt isolation and further evaluation for COVID: -Fever or chills -Cough -Shortness of breathe -Fatigue -Muscle or body aches -Headache -New loss of taste or smell -Sore throat -Congestion or runny nose (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Nausea or vomiting -Diarrhea -Reporting Requirements Nursing Care Facilities must report information about staff and residents that test positive for COVID as needed, within 24 hours after being diagnosed to the Department of Health Review of the Center for Disease Control and Prevention (CDC) Viral Respiratory Pathogens Toolkit for Nursing Homes dated 9/11/25, stated when levels in the community are higher, consider having visitors and HCP wear a mask at all times in the facility and at a minimum, consider having residents wear a mask when outside of their room. Review of the facility's surveillance tracking and mapping from September 2024 to September 2025, failed to include the following: -October 2024 (Failed to include map) -February 2025 (Failed to include map) -April 2025 (Failed to include room [ROOM NUMBER] on map) -August 2025 (failed to include tracking for Candida Auris positive residents for Resident R45 and R59) -September 2025 (Failed to include map) Review of information submitted to the State Agency on 8/22/25, revealed the facility was notified on 8/15/25, a resident tested positive for Candida Auris. It was indicated further testing would be needed for all current residents on the first floor. Facility is following local DOH guidelines for containment, isolation, sanitizing, notification, and testing. Review of the facility's Candida auris testing log sheet revealed Resident R45 and R59 were tested for Candida auris on 8/27/25. Review of Resident R45's clinical record revealed enhanced barrier precautions were ordered on 9/3/25, for Multi-drug resistant organism colonization (MDRO), a total of eight days after preliminary testing occurred. The facility failed to timely implement isolation precautions for Resident R45. Review of Resident R59's clinical record revealed enhanced barrier precautions were ordered on 9/3/25, for Multi-drug resistant organism colonization (MDRO), a total of eight days after preliminary testing occurred. The facility failed to timely implement isolation precautions for Resident R59. During an interview on 9/24/25, at 12:22 p.m. the Director of Nursing (DON) stated Resident R45 and R59 should have been on the infection control tracking and mapping for August 2025. The DON confirmed Resident R45 and R59 were colonized with C. auris. During an interview on 9/26/25, at 10:55 a.m. information disseminated to DON that the facility failed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to timely implement isolation precautions during preliminary testing for C. auris for Resident R45 and R59. Review of the facility's LTC Respiratory Surveillance Line List revealed Resident R116 began with symptoms on 8/18/25. The resident had a fever, cough, and chills. On 8/20/25, the resident was ordered a rapid test and the results were positive for COVID. Review of Resident R116's clinical record from 8/18/25, to 8/20/25, failed to include evidence droplet precautions were implemented for COVID-like symptoms. The facility failed to timely initiate droplet precautions for a resident with COVID-like symptoms. A further review of the facility's LTC Respiratory Surveillance Line List revealed the following: -Nurse Aide, Employee E16 tested positive for COVID on 8/22/25. -Nurse Aide, Employee E24 tested positive for COVID on 8/25/25. -Resident R54 tested positive for COVID on 8/26/25. -Resident R91 tested positive for COVID on 8/26/25. -Resident R50 tested positive for COVID on 8/28/25. -Resident R51 tested positive for COVID on 8/30/25. Review of information submitted to the State Agency from 8/22/25, to 8/31/25, failed to include evidence the facility reported newly identified cases of COVID within 24 hours as required for (NA, Employee E16, NA, Employee E24, Resident R50, R51, R54, and R91). During observations made on 9/22/25, through 9/24/25, facility staff and residents were not observed wearing source control throughout the facility during a COVID outbreak. During an interview on 9/24/25, at 12:24 p.m. the DON confirmed the facility failed to implement universal source control for residents and healthcare providers during a COVID outbreak. During an interview on 9/26/25, at 12:57 p.m. the Director of Nursing and Nursing Home Administrator were notified the facility failed to timely implement droplet precautions for Resident R116. The DON confirmed the facility failed to report newly identified positive COVID results within 24 hours. Review of the clinical record indicated Resident R91 was admitted to the facility on [DATE]. Review of Resident R91's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/25, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and anxiety. During a medication pass observation for Resident R91 completed on 9/24/25, at 8:57 a.m. Licensed Practical Nurse (LPN) Employee E8 failed to complete hand hygiene prior to, during and after the medication pass as required. During an interview completed on 09/24/25, at 9:33 am. LPN Employee E8 confirmed not completing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hand hygiene prior to, during and after the medication pass as required 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to discontinue a physician order for one of one resident (Resident R2), failed to provide appropriate care and services for a resident with a wound vac (Resident R16), failed to discontinue skin treatments (Resident R32), failed to obtain physician orders to provide parameters of when to notify the physician of increased/decreased Capillary Glucose levels (CBG) for one of three residents (Resident R89). Findings include: Review of the facility Wound Care policy last reviewed 7/11/25, indicated it is the facility's policy to provide guidelines for the care of wounds to promote healing. Verify that there is a physician order for wound care. Review the resident's care plan to assess for any special needs of the resident. Review of the facility policy Nursing Care of the Resident with Diabetes last reviewed 7/11/25, indicated diabetes is a disorder in which there is relative or absolute lack of insulin. Guidelines include but not inclusive to prevent recurrent hyperglycemia/hypoglycemia. Recognize, manage, and document the treatment of complications. Review the most common and serious conditions and complications associated with diabetes. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to brain cell damage or death), muscle weakness and aphasia (language disorder that affects a person's ability to communicate effectively). Review of Resident R2's admission MDS assessment (minimum data assessment)- periodic assessment of resident care needs) dated 9/6/25, indicated the diagnosis remained current. Review of Resident R2's physician orders dated 8/25/25 indicated that Resident R2 was ordered a Zio monitor (wearable, disposable device that continuously monitors the heart rhythm) - Long term-Monitor Zio patch Q shift for errors (orange flashing light) or dislodgement. If error noted, notify MD and call customer service [PHONE NUMBER] every shift. Review of Resident R2's Treatment Administration Record (TAR) indicated a 9 (see nurses notes) on 9/20/25, 9/21/25, and 9/22/25. Nurse's notes on these days revealed that monitor was not present. Interview with Resident R2's husband 9/23/25 at 11:00 a.m. indicated their son had taken the monitor to return the physician days before. Interview on 9/24/25 at 2:00 p.m. with Director of Nursing revealed that Resident R2 did not have the monitor and the physician order was not discontinued as required, Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/2/25, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and encounter for orthopedic aftercare following surgical amputation. Review of Resident R16's progress note dated 9/10/25, entered by Nurse Practitioner, Employee E13 indicated to cleanse the left plantar open surgical wound with normal saline. Apply wound vac per surgeon's request to base of the wound, and change three times per week. It was recommended to continue surgical orders for wound vac and follow up with surgeon as directed. Review of Resident R16's active physician order dated 9/10/25, revealed a wound vac to left foot, set to continuous therapy at 125 mmHg pressure every day shift, every Monday, Wednesday, and Friday. The physician order failed to include an order to cleanse the wound, apply black foam, and cover with drape. An order for a wet-to-dry dressing as needed if wound vac malfunctions was not included. Review of Resident R16's care plan dated 9/18/25, revealed a wound vac- Negative Pressure Wound Therapy (NPWT) care was to be applied to the resident's left foot and set to continuous therapy at 125 mmHg pressure. The care plan failed to include interventions to cleanse the wound, apply black foam, and cover with drape. During an interview on 9/23/25, at 11:34 a.m. Resident R16 stated I don't recall when asked if their wound vac is changed and cleansed three times a week. During an interview on 9/24/25, at 1:39 p.m. Resident R16 stated the wound vac dressing was not changed today yet. During an interview on 9/24/25, at 2:36 p.m. Licensed Practical Nurse, Employee E8 was asked if Resident R16's wound vac dressing was changed and replied no. LPN, Employee E8 stated the wound care nurse gave an order not to change it today. A review of Resident R16's clinical record on 9/24/25, at 2:46 p.m. failed to reveal evidence the resident's left foot wound was cleansed from 9/10/25, to 9/24/25. During an interview on 9/24/25, at 2:53 p.m. Wound Care Nurse, LPN, Employee E12 stated the Nurse Practitioner rounds the facility every Wednesday and sees everyone with open wounds. The facility follows the Nurse Practitioner's recommendations. The Nurse Practitioner documents orders in the resident's progress note, and Wound Care Nurse LPN, Employee E12 enters the order into the electronic record. LPN, Employee E12 stated the wound vac dressing orders are usually dependent on what the doctor orders. LPN, Employee E12 stated a wound cleanser, foam dressing, and pressure settings are included in the order to change the wound vac. A wet-to-dry order is entered if the wound vac malfunctions. If staff need clarification for orders, the wound nurse, supervisor, or surgeon can be notified. LPN, Employee E12 confirmed Resident R16 was not seen during wound care rounds today. LPN, Employee E12 stated the resident has a follow-up appointment, if a resident has follow-up appointment the wound group does not see them. Wound Care Nurse LPN, Employee E13 confirmed Resident R16's wound vac dressing was not changed as ordered on day shift on 9/24/25. During an interview on 9/24/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide appropriate care and treatment for a Resident R16's wound vac. Review of Resident R32's admission record indicated he was originally admitted on [DATE] and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readmitted on [DATE]. Review of Resident R32's MDS assessment dated [DATE], indicated he had diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), hyperlipidemia (elevated lipid levels within the blood), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R32's care plans dated 6/7/25, indicated to observe for changes in skin conditions. Evaluate and provide treatment as per physician's order. Review of Resident R32's physician order dated 8/27/25, indicated to provide ACE wrap (compression bandage made of stretchable cloth) to left elbow. On in morning and off at bedtime. Every day and evening shift for Bursitis (inflammation of the bursa-cushion sack of the bone). Provide for 14 days. Resident R32's physician order end date 9/11/25. Review of Resident R32's clinical progress notes dated 9/17/25, indicated he has been using ACE wraps daily. During observations on 9/23/25, at 11:07 a.m. Resident R32 was observed in the therapy area with left ACE wrap on his left arm. During an interview on 9/25/2025, at 10:09 a.m. Resident R32 observed again with ACE wrap, and he stated: I've had the wrap on my left arm for 2-3 weeks. During an interview on 9/25/25, at 11:19 a.m. interview with Licensed Practical Nurse (LPN) Employee E18 was asked about Resident R32 ACE wrap physician order: not sure if the order is still in there. Resident R32 insists on getting his arm wrapped. There is no order in there; it fell off. He gets the wrapping for bursitis. During an interview on 9/25/25, at 12:50 p.m. information was disseminated to the Nursing Home Administrator (NHA) that the facility failed to discontinue skin treatments as per physician order. Review of the clinical record indicated Resident R89 was admitted to the facility on [DATE]. Review of Resident R89's MDS assessment dated [DATE], indicated the diagnosis of diabetes (high sugar in the blood), hemiplegia affecting right side and dependence on renal dialysis. Review of Resident R89's physician orders dated 8/21/25, indicated accucheck before meals for diabetes on insulin. The order failed to provide parameters of when to notify the physician of increased/decreased Capillary Glucose levels (CBG). During an interview completed on 09/26/2025, at 9:45 a.m. the Director of nursing confirmed that Resident R89's physician orders did not include parameters of when to notify the physician of increased/decreased Capillary Glucose levels (CBG) for one of three residents (Resident R89). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.29(a) Resident rights 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for five out of five nurse aides (NA Employee E1, E2, E3, E4, E5). Findings include: During an interview on 9/25/25, at 1:30 p.m. the Human Resource Employee E6 confirmed that the facility does not have performance reviews completed on NA Employee E1, E2, E3, E4, and E5. During an interview on 9/25/25, at 1:30 p.m. Human Resource Employee E6 the confirmed that the facility failed to complete annual performance evaluations for five of five nurse aides as required. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development. 28 Pa Code: 201.14 (a) Responsibility of licensee.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to provide evidence medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for four of six residents (Resident R6, R10, R11, R59). Finding include: The facility Consultant Pharmacist reports: monthly report of pharmaceutical services last reviewed 7/11/25, indicated that the consultant pharmacist prepares monthly written reports on the status of the facility's pharmaceutical services and nursing staff performance related to medication therapy. Monthly reports are kept on file for at least two years. Review of the clinical record revealed Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/25/25, indicated diagnoses of depression, schizophrenia (affects thinking, feeling and behaviors) and high blood pressure. Review of Resident R6's physician orders dated 10/11/22, indicated Cymbalta (antidepressant medication) capsule delayed release particles 30 MG. Give 1 capsule by mouth at bedtime related to major depressive disorder. Review of R6's physician order dated 12/10/22, indicated Cymbalta capsule delayed release particles 60 MG. Give 1 capsule by mouth in the morning for depression. Review of Resident R6's physician orders dated 5/31/24, indicated Abilify (antipsychotic medication) oral tablet 5 milligrams (MG) by mouth at bedtime for schizoaffective disorder. Review of Resident R6's care plan initiated 10/6/21, indicated attempt psychotropic drug reduction. Review of Resident R6's clinical records and paper records for Medication Record Review (MRR) did not include any pharmacy reviews related to medication therapy. Review of Resident R10's admission record indicated she was originally admitted on [DATE] and readmitted on [DATE]. Review of Resident R10's MDS dated [DATE], indicated she had diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R10's care plan dated 6/27/25, indicated to review medication regimen. Review of Resident R10's Certified Registered Nurse Practicer (CRNP) progress note dated 9/15/25, indicated she was receiving a number of psychotropic (mood altering) medication and pain medication: (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ativan 0.5 mg, Klonopin 0.5 mg, Melatonin 5 mg, and Tramadol 50 mg. Review of Resident R10's clinical records and paper records for MRR and pharmacy reviews did not include any pharmacy reviews completed by her physician. Review of Resident R11's admission record indicated she was admitted on [DATE] and re-admitted on [DATE]. Review of Resident R11's MDS assessment dated [DATE], indicated she had diagnoses that included diabetes, schizoaffective disorder (a mental condition characterized by schizophrenia symptoms and shifts in mood), and depressive disorder (a state of consistent sadness and loss of interest interfering in daily life activities). Review of Resident R11's care plan dated 6/27/25, indicated to review drug regimen with physician and pharmacy. Review of Resident R11's physician order summary dated, indicated she was on the following psychotropic medications: Abilify 10 mg, Buspirone 15 mg, Gabapentin 100mg, and Melatonin 5 mg. Review of Resident R11's clinical records and paper records for MRR and pharmacy reviews did not include any pharmacy reviews completed by her physician. Review of the clinical record indicated Resident R59 was admitted to the facility on [DATE], with diagnoses of major depressive disorder, anxiety disorder and spinal stenosis (condition where the spinal canal, the space within the spine that houses the spinal cord and nerve roots, becomes narrowed). Review of Resident R59's Minimum Data Set (MDS - a period assessment of care needs) dated 8/10/25, indicated diagnoses were current. Review of Resident R59's Clinical Record failed to include Medication Record Review (MRR). -100mg Sertraline (antidepressant medication), daily -Lorazepam (a benzodiazepine medication used to treat anxiety, insomnia, and certain medical conditions), 0.5 mg twice daily During an interview on 9/25/25, at 12:07 p.m. the Director of Nursing confirmed the facility failed to provide evidence that medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for four of six residents (Resident R6, R10, R11, R59). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Beaver Valley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 257 Georgetown Road Beaver Falls, PA 15010	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner in one of two medication rooms (first floor medication room) and three of five medications carts (second floor South Hall, first floor South Hall and first floor [NAME] Hall). Findings include: Review of the facility policy Storage of Medications last reviewed 7/11/25, indicates medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The nurse will check the expiration date of each medication before administering it. Medication storage areas are kept clean, well lit, and free of clutter Review of the facility policy Administering Medications last reviewed 7/11/25, indicated the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi dose container, the date is recorded on the container. Review of the facility policy Insulin Pen Administration last reviewed 7/11/25, indicated take off the pen cap and check medication expiration date and overall appearance of pen and insulin. During an observation completed on 09/25/25, at 8:41 a.m. the first-floor medication room contained the following: Items stored under the sink: A white basket containing three blood spill kits and a flashlight One bottle drug buster One box of gloves One clear plastic lock box Three medication cart trash container lids A roll of plastic bags The First-floor medication room refrigerator contained the following: Three boxes of Sanofi Pasteur high dose flu vaccine with the expiration date of date 6/25 Three boxes of Sanofi Pasteur low dose flu vaccine with an expiration date of 6/25 One vial tubersol opened and failed to be labeled with a date The medication rooms refrigerator freezer section contained the following: Six Nordic ice packs Two instant ice packs During an interview completed on 9/25/25, at 9:01 a.m. Registered Nurse Employee E23 confirmed the above findings. During an observation on 9/23/25, at 9:13 a.m. the second-floor South medication cart contained the following: A bottle of Pepto Bismol opened and failed to be labeled with a date A bottle of Geri-tussin opened and failed to be labeled with a date A bottle of milk of magnesia opened and failed to be labeled with a date Two albuterol inhalers opened and failed to be labeled with a date A bottle of artificial tears opened and failed to be labeled with a date A bottle of timolol eye drops opened and failed to be labeled with a date During an interview completed on 9/23/25, at 9:22 a.m. Licensed Practical Nurse (LPN) Employee E19 confirmed the above findings. During an observation on 9/23/25, at 9:13 a.m. the first-floor South medication cart contained the following: A trilogy inhaler opened and failed to be labeled with a date. During an interview completed on 9/25/25, at 11:38 a.m. LPN Employee E7 confirmed the above finding. During an observation completed on 9/25/25, at 11:39 AM the first-floor [NAME] medication cart contained the following: A Lantus insulin pen not stored in a bag During an interview completed on 9/25/25, at 11:45 a.m. LPN E21 confirmed the above finding. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, and staff interviews, it was determined that the facility failed to determine the ability to self-administer medications for one of six residents (Residents R16). Findings include: Review of the facility policy Self-Administration of Medication last reviewed 4/1/25, indicated the facility, in conjunction with the interdisciplinary care team, should assess and determine whether self-administration of medications is safe and clinically appropriate. The facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer. If a resident self-administers their medication the facility should routinely assess the residents cognitive, physical, and visual ability. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/2/25, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and muscle weakness. Observation on 9/23/25, at 11:34 a.m. Resident R16 was observed with two packs of red pills in bed. The medication was labeled Coricidin HBP (a cold medication specifically formulated for individuals with high blood pressure, providing effective relief from cold and flu symptoms without raising blood pressure.) During an interview on 9/23/25, at 11:50 a.m. Licensed Practical Nurse, Employee E7 confirmed Resident R16 was left unattended with medications. LPN, Employee E8 confirmed Resident R16 failed to have an order for the medication or a care plan for self-administration of medications. During an interview on 9/23/25, at 11:51 a.m. the Director of Nursing confirmed the facility failed to determine the ability to self-administer medications for one of six residents (Residents R16). 28 Pa code: 211.12 (d) (1) (5) Nursing services.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and resident and staff interviews, it was determined that the facility failed to the notify resident representative and/or medical provider of a change in condition/status for one of three residents (Resident R66). Findings include: Review of the facility policy Accidents and Incidents- Investigation and Reporting last reviewed 7/11/25, indicated all accidents or incidents involving residents, employees, visitors, vendors etc., occurring on premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and /or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data should be included but not inclusive to the date/time the family was notified and by whom. The time the attending physician was notified as well as the physician's response and instructions. Review of the clinical record indicated Resident R66 was admitted to the facility on [DATE]. Review of Resident R66's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/6/25, included diagnoses of heart failure (heart doesn't pump the way it should), anxiety and depression. Section C0500 Brief Interview of Mental Status (BIMS is a brief screener that aids in detecting cognitive impairment) Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Resident R66's BIMS score coded as 13 indicating cognitively intact. Review of Resident R66's demographic profile indicated son as emergency contact. During an interview completed on 9/23/25, at 12:00 p.m. concerning a recent event that took place on 9/21/25, Resident R66 stated I was surprised they didn't call my family members, I don't even think they know about it. Review of Resident R66's progress notes for event date of 9/21/25, failed to include family or physician notification. During an interview completed on 09/23/25, at 2:39 p.m. the Director of Nursing confirmed that the family member and physician did not receive notification of an event on 9/21/25, and that the facility failed to the notify resident representative and/or medical provider of a change in condition/status for one of three residents (Resident R66). 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF-ABN) for one of three sampled resident records (Closed Resident Record CR132). Findings include: The facility How to implement ABN's last reviewed 7/11/25, indicated that the purpose of a SNF-ABN is to inform the Medicare beneficiary that Medicare may not pay for particular services. If the resident will continue in the nursing facility under a different payor source to issue a current SNF-ABN letter on or before the last cover day. Review of Closed Resident Record CR132's admission record indicated she was admitted on [DATE]. Review of Closed Resident Record CR132's MDS Assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 3/10/25, indicated she had diagnoses that included anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), depressive disorder (a state of consistent sadness and loss of interest interfering in daily life activities) and hypertension (a condition impacting blood circulation through the heart related to poor pressure). These were the most recent diagnoses upon review.Facility documentation indicated that Closed Resident Record CR132 started Medicare Part A skilled services on 3/7/25 and those services ended 3/13/25.Review of Closed Resident Record CR132's progress notes indicated she was discharged to personal care on 5/2/25. Further review of clinical documentation did not indicate she was provided with a SNF-ABN prior to her Medicare Part A services ending on 3/13/25.During an interview on 9/24/25, at 11:52 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF-ABN) for Closed Resident Record CR132 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(2)(3) Management		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, facility documents, and staff interviews it was determined that the facility failed to identify a seat belt and table attached to a wheelchair and leg straps placed over a residents thighs as a possible restraint, and failed to assess the functional status of the individual residents to determine if the use of a seatbelt or table attached to a wheelchair and leg straps placed over a residents thighs is a restraint for two of four residents (Residents R15 and R58). Findings include: Review of facility policy Use of Restraints dated 7/11/25, stated restraints shall only be used to treat the resident's medical symptom and never for discipline or staff convenience, or for the prevention of falls. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. Examples of devices that are/may be considered physical restraints include leg restraints, geri-chairs, and trays that the resident cannot remove. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including using devices in conjunction with a chair, such as trays, tables, belts, that the resident cannot remove and prevents the resident from rising. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the specific reason for the restraint (as it related to the resident's medical symptom), how the restraint will be used to benefit the resident's medical symptoms, and the type of restraint, and period of time for the use of the restraint. Restrained individuals shall be reviewed regularly (or at least quarterly) to determine whether they are candidates for restrain reduction, less restrictive methods of restraints, or total restraint eliminations. Review of the admission record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's care plan dated 12/30/24, indicated use of assistive/adaptive equipment-wheelchair. The facility failed to provide a description of the assistive/adaptive equipment and its purpose. Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of high blood pressure, cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), and muscle weakness. During an observation on 9/23/25, at 12:24 p.m. Resident R15 was observed sitting in a wheelchair with a seat belt across their legs and a table attached to the left side. Review of Resident R15's active physician orders on 9/23/25, failed to include an order for a seat belt or table to their wheelchair. Review of Resident R15's clinical record failed to identify any assessments or ongoing evaluations for (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the use of a seat belt or table. Review of the clinical record failed to include documentation identifying the medical symptom being treated and an order for the use of the specific type of seat belt and table attached to the wheelchair. Review of the admission record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of Huntington's disease (a disorder that causes uncontrolled movement and problems with balance, walking, speaking, swallowing, thinking and regulating emotions), anemia (low iron in the blood) and anxiety. Review of Resident R58's care plan dated 11/20/23, indicated use of assistive/adaptive equipment-wheelchair. The facility failed to provide a description of the assistive/adaptive equipment and its purpose. During an observation completed on 9/22/25, at 11:30 a.m. Resident R58 was observed sitting in his Broda chair, the chair had two burgundy leg straps placed over his thighs the straps were clipped in place on the back of the chair. During an interview completed on 9/22/25, at 1:04 p.m. Licensed Practical Nurse (LPN) Employee E19 confirmed the leg straps were place over Resident R58's thighs. Upon asking LPN Employee E19 the use for the leg straps stated, I don't know why, hospice orders these chairs, I think it's because he slides. During an interview completed on 9/22/25, at 1:21 p.m. LPN Employee E12 stated Resident R58 is usually out of bed and in the chair daily unless he is not feeling well and stated, I don't know why he has straps; they just put him back in bed. LPN Employee E12 confirmed the straps were in the chair and had a clip that is placed to the back of the chair. LPN Employee E12 stated that is not typically one of our chairs I was not aware of them. Upon review of Resident R58's physician orders LPN Employee E12 was not able to identify orders for the straps and stated I don't know where they came from this is the first time seeing them, I would expect to see orders. During an interview completed on 9/22/25, at 1:21 p.m. upon asking the Director of rehabilitation Employee E20 concerning the use of leg straps to a Broda chair replied, I have never seen anyone with leg straps on a chair it would be considered to be a restraint, I am not aware that Resident R58 has leg straps on his chair he has not been on therapy for positioning from before April, I know nothing about the leg straps, I would consider them to be a restraints we don't order straps to chairs, hospice provides those chairs for the residents. Hospice has never spoken to me about the leg straps. We would not use them as it would be a restraint. The resident cannot remove them. During an interview completed on 9/22/25, at 1:57 p.m. The Director of Nursing stated we don't consider it (the leg straps) a restraint as it came with the chair, hospice supplied it, we considered it adaptive equipment. The DON further stated, he can't release it himself and confirmed that the leg straps were not identified as a restraint. During an interview on 9/24/25, at 12:30 p.m. the Director of Nursing confirmed that the facility failed to identify a seat belt and table attached to a wheelchair and leg straps placed over a residents thighs as a possible restraint, and failed to assess the functional status of the individual residents to determine if the use of a seatbelt or table attached to a wheelchair and leg straps placed over a (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents thighs is a restraint for two of four residents (Residents R15 and R58). 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that each resident's drug regimen was free from unnecessary psychotropic drugs used without adequate indications for use for one of three residents (Resident R98). Findings include: Review of Resident R98's admission record indicated she was initially admitted to the facility on [DATE]. Review of Resident R98's Minimum Data Set (MDS- periodic assessment of care needs) assessment dated [DATE], included diagnoses of depression, metabolic encephalopathy (a change in how your brain works due to an underlying condition), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). No psychotic diagnoses were present on the MDS. Review of Section N: Medications revealed Resident R98 received antipsychotic medications in the seven days prior to the assessment. Review of the facility diagnoses list indicated, dementia in other diseases classified elsewhere, mild, with anxiety. Review of a physician order dated 7/8/25, discontinued 8/27/25, indicated to administer 100 milligram (mg) quetiapine (an anti-psychotic medication), give two tablets by mouth at bedtime for psychosis. Review of Resident R98's active physician order dated 8/27/25, indicated Resident R98 to administer 100 mg quetiapine), give one tablet by mouth at bedtime for psychosis. Review of Resident R98's clinical record failed to include a diagnosis of psychosis. Review of Resident R98's care plan initiated 7/29/25, revealed the resident is at risk for adverse side effects related to use of antipsychotic medication. Review of behavior monitoring documentation from 7/8/25, through 9/23/25, revealed that Resident R98 was documented as having no behaviors for each shift documented. Review of a psychiatric progress note dated 7/30/25, indicated the resident's spouse reports the resident has been on quetiapine for about two years and feels that it continues to be beneficial. Review of a psychiatric progress note dated 9/2/25, revealed the resident denied suicidal and homicidal ideations, agitation, hallucinations or delusions. The resident also denies feelings of depression or anxiety. During an interview on 9/24/25, at 4:07 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to make certain that each resident's drug regimen was free from unnecessary drugs used without adequate indications for use for one of three residents (Resident R98). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.2(a)(c) Physician services. 28 Pa. Code: 211.9(a)(1)(d)(k) Pharmacy services.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records and staff interview it was determined that the facility failed to ensure an appropriate discharge for one of three residents and failed to notify the ombudsman of the correct living arrangement for one of three residents (Closed Record Resident R131). Findings include: Review of Closed Record Resident R131 was admitted on [DATE]. Review of Closed Record Resident R131 MDS (minimum data set - a periodic assessment of resident needs) dated 3/23/25, indicated diagnosis of anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) hyperlipidemia (excess of lipids or fats in your blood), and respiratory failure (is a condition where there is not enough oxygen or too much carbon dioxide in the body). Review of facility documentation indicated that Closed Record Resident R131 on 4/2/25, was found in the parking lot with what appeared to be aluminum foil shaped into what appeared to be pipe and a white substance. Review of facility documentation discharge summary indicated the following: Resident R131 was admitted to the facility from the hospital, on 3/17/25, for further nursing care and will need case management and social service involvement regarding his current home status. In addition, the clinical record indicated Had about couple day period of disruptive behaviors and concern for drug use, but UDS was negative. he tolerated all other treatments, and no acute issues arose during facility stay. He is discharging to a hotel for now then followed by homeless shelter. Review of clinical record indicated that reside was in a program called Crossroads which is a drug and alcohol treatment facility. During an interview on 9/25/25, at 11:06 a.m. at Employee E14 Social Services indicated the following Closed Record Resident R131 was admitted to the facility with housing, and listed as homeless, he had no finances while a Resident at the facility and confirmed he was discharged to a motel/hotel. Review of the clinical record failed to include a referral for housing. Review of facility documentation indicated a notice to the ombudsman office for 30-day discharge. The address on the from indicated Closed Record resident R131 former address and not the address for the motel/hotel or the homeless shelter. During an interview on 9/26/25, at 9:49 a.m. NHA (Nursing Home Administrator) confirmed that the facility failed to identify a housing facility for the resident and failed to identify the correct discharge placement to the ombudsman for Closed Record Resident R131. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.29(a)(c) (2)Resident rights.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for one of four residents (Resident R8). Findings include: Review of the facility policy Certifying Accuracy of the Resident Assessment last reviewed 7/11/25, indicated any person completing a portion of the Minimum Data Set (MDS-resident assessment instrument) must sign and certify the accuracy of that portion of the assessment. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's MDS dated [DATE], indicated diagnoses of heart failure (heart doesn't pump the way it should), anxiety and depression. Section P0100 Physical Restraints used in bed: A-Bed rail coded as used daily. Review of the facility provided resident matrix on 9/22/25, indicated Resident R8 had a physical restraint. Review of Resident R8's clinical record failed to include a physician order for bedrail restraints. During an observation completed on 9/22/25, at approximately 12:05 p.m. Resident R8 was in bed, bilateral enabler bars were noted to bed. During an interview completed on 9/24/25, at 12:43 p.m. MDS Coordinator Employee E22 confirmed Resident R8's MDS was coded for the use of restraints and stated, oh I can't believe I did that; it was probably when I was working off my phone and confirmed that the facility failed to ensure MDS assessments accurately reflected the resident's status for one of four residents (Resident R8). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop a baseline care plan for one of three residents (Resident R4). Findings include: Review of facility policy Care Plans-Baseline last reviewed 7/11/25, indicated a baseline plan of care to meets the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. The baseline care plan will be used until the staff can conduct the comprehensive assessment and interdisciplinary person-centered care plan. Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/6/25, indicated diagnoses of anemia (low iron in the blood), high blood pressure, and diabetes (high sugar in the blood). Review of Resident R4's admission evaluation section 9 baseline care plan/order review was checked no. During an interview completed on 9/24/25, at 12:57 p.m. the Director of Nursing confirmed Resident R4's baseline care plan was not completed as required and that the facility failed to develop a baseline care plan for one of three residents (Resident R4). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, review of clinical record, observation, and resident and staff interview, it was determined that the facility failed to provide appropriate foot care to one of six residents (Residents R15). Findings include: The facility's Foot Care dated 7/11/25, stated residents will receive appropriate care and treatment in order to maintain mobility and foot health. Residents will be assisted in making transportation appointments to and from specialist (podiatrists) as needed. Review of the admission record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/3/25, indicated diagnoses of high blood pressure, cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), and muscle weakness. Review of Resident R15's physician order dated 6/3/25, indicated to consult podiatry for toenail trim. During an interview and observation on 9/23/25, at 10:37 a.m. Resident R15 stated my toenails are long, I never seen a podiatrist, not one. Resident R15 was observed with overgrown toenails. During an interview on 9/23/25, at 10:41 a.m. Nurse Aide, Employee E16 confirmed Resident R15's toenails were thick, elongated and curved with a length that varied from approximately one-half inch to one inch over the ends of the toes. During an interview on 9/23/25, at 10:53 a.m. the Assistant Director of Nursing, Employee E17 indicated residents who receive Medicare/Medicaid see podiatry in-house and skilled residents are sent out to the community. Interview on 9/23/25, at 1:44 p.m. the Director of Nursing confirmed that Resident R15 did not received Podiatry care since admission and that the facility failed to provide appropriate foot care to one of five residents (Residents R15). 28 Pa. Code 201.21(c) Use of outside resources. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical records, and staff interviews, it was determined that the facility failed to provide prescribed treatment and services related to the care of a PICC line (peripherally inserted central catheter, a long, thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart) for two of two residents (Resident R16 and R42). Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/2/25, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and encounter for orthopedic aftercare following surgical amputation. Review of Resident R16's care plan dated 8/27/25, indicated to change IV site dressing per physician order and as needed if soiled or wet. Review of Resident R16's physician order dated 9/10/25, stated to change the PICC dressing and caps every seven days. Review of Resident R16's September Treatment Administration Record (TAR) record revealed Registered Nurse, Employee E9 documented that Resident R16's PICC line dressing was changed on 9/17/25. During an observation on 9/24/25, at 2:33 p.m. Resident R16's PICC line dressing was dated 9/9/25. During an interview on 9/24/25, at 2:36 p.m. Licensed Practical Nurse, Employee E8 confirmed Resident R16's PICC line dressing was dated 9/9/25. LPN, Employee E8 confirmed the facility failed to change Resident R16's PICC line dressing as ordered. Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R42's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/4/25, indicated diagnoses of high blood pressure, muscle weakness, and pneumonia. Review of Resident R42's care plan dated 6/25/25, indicated to change IV site dressing per physician order and as needed if soiled or wet. Review of Resident R42's physician orders on 9/22/25, failed to include an order to change the PICC dressing and caps every seven days. During an observation on 9/22/25, at 11:11 a.m. Resident R42's upper left arm PICC dressing was undated. During an interview on 9/22/25, at 11:18 a.m. Registered Nurse, Employee E10 confirmed Resident R42's PICC line was undated. During an interview on 9/22/25, at 11:23 a.m. Licensed Practical Nurse (LPN), Employee E11 stated orders to change IV dressings are located in the electronic record. LPN, Employee E11 confirmed Resident R42 failed to have an order for the PICC line and an order to change the PICC line dressing. During an interview on 9/24/25, at 2:45 p.m. the Director of Nursing the facility failed to provide prescribed treatment and services related to the care of a PICC line for two of two residents (Resident R16 and R42). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to make certain consistent dialysis communication was maintained for one of two residents (Residents R89) and ensured fluid restrictions were maintained for one of two residents (Resident R89). Findings include: Review of the facility policy Encouraging and Restricting Fluids last reviewed 7/11/25, indicated to provide the resident with the amount of fluids necessary to maintain optimum health this may include encouraging or restricting fluids. The following information should be recorded in the resident's medical record that includes but not inclusive to the amount in millimeters of fluids consumed by the resident during the shift. Review of the clinical record indicated Resident R89 was admitted to the facility on [DATE]. Review of Resident R89's MDS assessment dated [DATE], indicated the diagnosis of diabetes (high sugar in the blood), hemiplegia affecting right side and dependence on renal dialysis. Review of Resident R89's physician order dated 2/26/24, indicated Obtain Vital Signs after Dialysis on Monday, Wednesday, and Friday. Review of Resident R89's physician order dated 3/3/24, indicated the resident receives hemodialysis at an outside facility every Monday, Wednesday, and Friday. Chair time 6:00 a.m. pick up 5:30 a.m. Obtain full set of vital signs pre dialysis Review of Resident R89's care plan with revision on 3/16/22, indicated Renal Insufficiency related to End Stage Renal Disease with intervention that include but not inclusive to: Coordinate dialysis care with the dialysis treatment facility. Obtain full set of vital signs pre dialysis Obtain post Dialysis vital signs in the afternoon Review of Resident R89's dialysis communication forms dated 8/1/25, through 9/22/25, revealed the following: 8/1/25, not completed by facility nurse upon return from dialysis. 8/6/25, not completed by facility nurse upon return from dialysis. 8/11/25, not completed by facility nurse upon return from dialysis. 8/15/25, not completed by dialysis facility and not completed by facility nurse upon return from dialysis. 8/16/25, not completed by facility nurse prior to dialysis and not completed by facility nurse upon return from dialysis. 8/20/25, not completed by facility nurse upon return from dialysis. 8/25/25, not completed by facility nurse upon return from dialysis. 8/29/25, not completed by dialysis facility and not completed by facility nurse upon return from dialysis. 8/27/25, not completed by facility nurse upon return from dialysis. 9/1/25, not completed by facility nurse upon return from dialysis. 9/3/25, not completed by facility nurse upon return from dialysis. 9/5/25, not completed by facility nurse upon return from dialysis. 9/8/25, not completed by facility nurse upon return from dialysis. 9/12/25, not completed by facility nurse upon return from dialysis. 9/15/25, not completed by facility nurse upon return from dialysis. 9/17/25, not completed by facility nurse upon return from dialysis. Review of Resident R89's physician's order dated 8/26/24, revealed the resident was ordered a 1200milliliter (ml) daily fluid restriction. Dietary to give total of 840ml: breakfast 240ml, lunch 240ml, dinner 240ml and 120ml hour sleep. The following free water fluid restrictions for nursing were ordered: day shift 120ml, evening shift 120, and night shift 120ml. Document in ml for shift and daily totals. Review of Resident R89's care plan dated 6/25/24, indicated at risk for alteration in hydration related to fluid restriction with interventions that included but not inclusive to: Report changes related to signs of fluid overload Report signs of edema or changes in edema level During an interview completed on 9/26/25, at 9:19 a.m. Registered Nurse (RN) Employee 23 stated, the fluid amount recorded is a combination total of both dietary and nursing. Review of Resident R89's fluid intake log completed on 9/26/25, for the time period 8/28/25, through 9/25/25, revealed the following: Date: Daily Fluid Amount Ordered: Actual Recorded Fluid Amount: 8/30/25: 1,200ml 1,840 ml 8/31/25: 1,200ml 1,960 ml 9/6/25: 1,200ml 1,960 ml 9/7/25: 1,200ml 1,574 ml 9/13/25: 1,200ml 1,640 ml 9/14/25: 1,200ml 1,530 ml 9/20/25: 1,200ml 1,590 ml 9/21/25: 1,200ml 1,550 ml 9/22/25: 1,200ml 1,780 ml 9/23/25: 1,200ml 1,460 ml During an interview completed on 9/26/25, at 9:19 a.m. RN Employee E23 confirmed that Resident R89's fluid intake was not maintained as ordered. During an interview completed on 9/26/25, at 9:45 (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. the Director of Nursing confirmed that the facility failed to make certain consistent dialysis communication was maintained for one of two residents (Residents R89) and ensured fluid restrictions were maintained for one of two residents (Resident R89). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R1). Findings include: Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with the diagnosis of Post Traumatic Stress Disorder (PTSD-a mental health condition in people who have experienced or witnessed a traumatic event), diabetes (high sugar in the blood) and heart failure (heart doesn't pump the way it should). Review of R1's minimum data assessment (MDS- periodic assessment of resident care needs) dated 8/2/25, indicated diagnosis are current. Review of Resident R1's care plan dated 7/18/22, indicated - At risk for changes in mood related to bipolar disorder, post-traumatic stress disorder chronic, agoraphobia with panic disorder, anxiety disorder. The care plan failed to identify PTSD triggers for Resident R1. Interview completed 9/26/25, at 8:56 a.m. Social Services Employee E24 confirmed that the facility failed to identify PTSD triggers for Resident R1 and that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on review of facility documentation, clinical record and staff interview it was determined that the facility failed to provide medically related social services for one of three residents reviewed (Closed Record Resident R131). Findings include: Review of Closed Record Resident R131 MDS (minimum data set - a periodic assessment of resident needs) dated 3/23/25, indicated diagnosis of anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) hyperlipidemia (excess of lipids or fats in your blood), and respiratory failure (is a condition where there is not enough oxygen or too much carbon dioxide in the body). Review of facility documentation indicated that Closed Record Resident R131 on 4/2/25, was found in the parking lot with what appeared to be aluminum foil shaped into what appeared to be pipe and a white substance. Review of clinical record follow up dated 4/11/25, indicated: Past Medical History: Active Medical Problems: Opioid dependence - Drug use history of Assessment and Plan: 1. Opioid dependence - on chronic suboxone 8-2mg tid> sent script electronically for 2-week supply - to be given to patient at DC and then follow up with his clinic Receives med at Crossroads clinic. Diagnosis's - Opioid dependence, uncomplicated. During an interview on 9/25/25, at 11:06 a.m. at Employee E14 Social Services indicated the following Closed Record Resident R131 was admitted to the facility with housing, and listed as homeless, he had no finances while a Resident at the facility and confirmed he was discharged to a motel/hotel. Review of the clinical record failed to include a referral for drug and alcohol treatment or any communication with Crossroads clinic. During an interview on 9/26/25, at 9:49 a.m. NHA (Nursing Home Administrator) confirmed that the facility failed to facility for the resident and failed to identify the correct discharge placement to the ombudsman for Closed Record Resident R131. 28 Pa. Code 211.10 (a) Resident care policies		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for two of five residents reviewed (Residents R89 and R91). Findings include: Review of the facility policy Medication Administration-General Guidelines last reviewed 7/11/25, indicated that medications are administered as prescribed in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the attending physician. Review of the facility policy Administering Medications last review 7/11/25, indicated medications are administered in accordance with prescriber orders. Medication administration times are determined by resident need and benefit, not staff convenience. Review of the facility policy Insulin Pen Administration last reviewed 7/11/25, indicated to administer insulin subcutaneously using a pen in a safe, accurate and effective manner. Procedure steps include but are not inclusive to: Wash hands with soap and water. Remove the seal from a new pen needle and attach it to the pen. Perform a safety test before each dose. Select a dose of two units of insulin by turning the dose selector. Hold the pen with the needle facing upward. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out the needle tip. If no insulin comes out, check for air bubbles and repeat the safety test up to two more times. Review of the clinical record indicated Resident R89 was admitted to the facility on [DATE]. Review of Resident R89's MDS assessment dated [DATE], indicated the diagnosis of diabetes (high sugar in the blood), hemiplegia affecting right side and dependence on renal dialysis. Review of Resident R89's physician order dated 2/26/24, indicated Dialysis on Monday, Wednesday, and Friday. Review of Resident R89's physician order dated 8/17/2023, indicated may administer morning (AM) medications following return from dialysis. Review of Resident R89's care plan initiated 12/07/21, indicated confer with physician and/or dialysis treatment facility regarding changes in medications times/dosages. May administer morning medications upon return from dialysis. Review of Resident R89's September Medication Administration Record indicated that on 9/15/25, and 9/24/25, the following medications/procedures were not completed and were coded as 9 - see nursing note. The nursing notes for 9/15/25, and 9/24/25, indicated dialysis. Accuchecks before meals scheduled times missed 7:30 a.m. and 11:30 a.m. Sevelamer carbonate 800 milligrams (mg) give three tablets before meals and at bedtime the scheduled time missed 8:30 a.m. and 12:00 p.m. Humalog Insulin lispro (fast acting) pen inject 4 units before meals scheduled times missed 7:30 a.m. and 11:30 a.m. Lantus insulin (long acting) inject 15 units two times a day missed scheduled for morning. Acetaminophen 325mg two tablets three times a day scheduled time missed 7:30 a.m. Aspirin 81 mg one tablet missed in the afternoon Gabapentin 100mg two tablets two times a day scheduled time missed 9:00 a.m. levetiracetam 750mg give two tablets two times a day missed 12:30 p.m. During an interview completed on 9/25/25, at 2:36 p.m. the Director of Nursing confirmed that Resident R89 did not receive his medications/procedures as ordered and stated, I am going to speak with pharmacy to arrange a new schedule around dialysis times. Review of the clinical record indicated Resident R91 was admitted to the facility on [DATE]. Review of Resident R91's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/25, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and anxiety. Review of Resident R91's physician orders dated 4/8/25 indicated Insulin Aspart (fast acting) subcutaneous solution pen-injector. Inject 10 unit subcutaneous before meals. During a medication observation completed on 9/24/25, at 9:07 a.m. for Resident R91 Licensed Practical Nurse (LPN) Employee E8 failed to prime the insulin pen as required. During an interview on 9/24/25, at 9:33 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed not priming the insulin pen needle. During an interview completed on 9/25/25, at 2:36 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents are free of significant medication errors for two of five residents reviewed (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Residents R89 and R91). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) 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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility policy review, review of the Quality Assurance attendance records, and staff interview it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all required members for one of three quarters (Quarter one of 2025). Findings include: The facility policy Quality Assurance and Performance Improvement (QAPI) Plan dated 7/11/25, indicated This facility shall develop, implement and maintain an on-going, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. Review of Quality Assurance and Performance minutes sign in sheets and attendance records for Quarter One of 2025, failed to reveal the Medical Director was in attendance. During an interview 9/26/25, at 1:15 p.m. NHA (Nursing Home Administrator confirmed that the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly with all the required committee members for one of three quarterly meetings (Quarter one 2025), as required. 28 Pa. Code 201.18 (e)(1)(2)(3)(4) Management.		