| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395273 | A. Building<br>B. Wing | 05/08/2026 |

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| Embassy of Scranton | 824 Adams Avenue<br>Scranton, PA 18510 |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on staff interviews, review of personnel records, employee credentials, facility documentation, and dietary service records, it was determined that the facility failed to ensure the registered dietitian (RD) provided the required on-site oversight of the food and nutrition services department.Findings include: According to current federal regulatory guidance the facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. In the absence of a full-time qualified dietitian, the director of food and nutrition services, the facility must designate a person to serve as the director of food and nutrition services. The director of food and nutrition services must at a minimum meet one of the following qualifications:(A) A certified dietary manager; or(B) A certified food service manager; or(C) Has similar national certification for food service management and safety from a national certifying body; or(D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and must receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. A review of the facility-provided job description for the Registered Dietitian (RD) revealed the position was responsible for planning, organizing, developing, and directing resident nutritional care in accordance with current federal, state, and local standards, guidelines, regulations, and facility policies and procedures. The documented major duties and responsibilities of the position included providing registered dietitian services at one or more facilities in accordance with facility policies and procedures; planning, organizing, developing, and directing nutritional care services for residents; assessing and monitoring residents' nutritional status and providing recommendations to clinical and medical staff; observing resident meal services to ensure prescribed diets and diet modifications were followed; educating residents, families, and staff regarding nutrition concepts and dietary modifications; collaborating with members of the interdisciplinary team to ensure modified texture diets and therapeutic diets were appropriate for the resident's medical condition; reviewing menu changes to ensure compliance with facility policy as well as state and federal guidelines; updating diet orders and menu changes as required; conducting routine audits of nutritional care practices; completing nutritional assessments upon admission, readmission, quarterly, annually, and with significant changes in condition; inspecting food service areas for sanitation, organization, safety, and proper staff performance; monitoring residents for weight changes, nutritional support needs, and skin breakdown and making recommendations as indicated; and participating in inspection surveys to ensure compliance with nutritional and dietary policies and procedures in accordance with state and federal requirements. A review of the facility's documented dietitian's role and responsibilities<br>(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 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | revealed the RD was responsible for timely documentation of resident weight losses within PCC (Point Click Care, the facility's electronic health record system), completion of comprehensive nutritional assessments, review of laboratory values and meal intake records, completion of nutrition-focused physical assessments, and updating resident care plans related to nutritional needs. During an interview on May 5, 2026, at 11:49 AM, the facility's dietary manager reported the facility's long-term Registered Dietitian had resigned and stated she was unsure who was currently covering the position. The dietary manager further stated no routine clinical nutrition coverage was provided on-site at the facility. During an interview on May 5, 2026, at 1:30 PM, the Nursing Home Administrator (NHA) confirmed Employee 12, the former Registered Dietitian, resigned with a last day worked of April 24, 2026. The NHA stated a remote (off-site and not present in facility) Registered Dietitian provided coverage after the resignation and confirmed the remote RD also provided services to sister facilities. A review of the remote Registered Dietitian's time records from April 24, 2026, through May 8, 2026, revealed the following off-site hours were documented for the facility:April 30, 2026: 1.5 hoursMay 1, 2026: 1.25 hoursMay 5, 2026: 1.25 hoursMay 6, 2026: 2.5 hoursMay 7, 2026: 2.0 hours The documented hours reflected limited off-site consultation coverage and revealed no documented evidence the Registered Dietitian routinely provided on-site oversight of the facility's food and nutrition services department. During a phone interview on May 8, 2026, at 8:55 AM, the facility's corporate Registered Dietitian confirmed the remote Registered Dietitian did not routinely conduct on-site oversight of the dietary department, staff training, direct resident observations for nutritional assessments, or monitoring of meal services. The corporate RD further reported she had no knowledge regarding untimely nutritional documentation or specific resident nutritional concerns occurring within the facility. The facility failed to ensure routinely scheduled on-site consultation and clinical oversight by a qualified Registered Dietitian or other clinically qualified nutrition professionals following the resignation of the facility's Registered Dietitian. The facility utilized a remote Registered Dietitian who did not routinely provide on-site oversight of resident nutritional care, meal service observations, dietary operations, or direct resident nutritional assessments. The facility's failure to provide adequate on-site Registered Dietitian oversight for the clinical aspects of food and nutrition services created the potential for inadequate monitoring and follow-up of residents with weight loss or nutritional concerns, incomplete or untimely nutritional assessments and documentation, deficient oversight of meal services and dietary operations, and lack of coordination of residents' clinical nutritional care needs. F692, F803 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18 (b)(1)(3)(e)(1)(6) Management. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility records, observations, and resident and staff interviews, it was determined the facility failed to ensure meals were prepared and served in accordance with the planned menu, failed to provide nutritionally comparable substitutions when menu items were unavailable, failed to document and review substitutions by a Registered Dietitian and failed to notify residents of menu changes for seven of 22 residents interviewed (Residents 11, 15, 39, 59, 60, 74, and 76). Findings include: A review of a facility policy entitled Menu Substitution Policy last reviewed by the facility on March 26, 2026, indicated the purpose of the policy was to ensure residents of the long-term care facility receive nutritionally adequate meals while honoring physician's orders, therapeutic diets, food allergies, cultural and religious preferences, and resident rights when menu substitutions are necessary. The facility shall provide appropriate food substitutions when planned menu items are unavailable, refused, contraindicated, or inconsistent with a resident's prescribed diet or preferences. All substitutions shall be nutritionally comparable and consistent with the resident's care plan, physician's orders, and dietary restrictions. Additionally, all substitutions must be nutritionally comparable to the original item, be documented according to facility when clinically significant, and be reviewed and signed off by the Registered Dietitian (RD). An observation of the facility's planned menu served during the survey, beginning Tuesday, May 5, 2026, through Friday, May 8, 2026, revealed the facility utilized Fall/Winter Menu 2025-2026, Week 2. Review of the Week 2 menu posted on the second-floor resident bulletin board revealed the planned lunch meal for Tuesday, May 5, 2026, included sausage and sauerkraut, warm German potato salad, seasoned carrots, and chilled tropical fruit cup. The posted alternative or always available menu included hamburgers, chef salad, grilled ham and cheese, or peanut butter and jelly. Observation of the lunch meal service on the second floor on May 5, 2026, at 12:28 PM, revealed residents were served kielbasa (a seasoned smoked sausage), mashed potatoes, and sauerkraut. Resident meal trays did not contain the planned warm German potato salad, seasoned carrots, or chilled tropical fruit cup listed on the posted menu. An interview with Resident 39, a cognitively intact resident, on May 5, 2026, at 1:00 PM, revealed meals were frequently not served as listed on the weekly menu. Resident 39 stated food items were often substituted or omitted without replacement. Resident 39 reported disliking the lunch meal consisting of kielbasa, mashed potatoes, and sauerkraut and stated a staff member was obtaining food from outside the facility to accommodate her preferences. Resident 39 reported her meal preferences were not being honored or updated. Interviews conducted with cognitively intact Residents 11, 15, 59, 60, 74, and 76 on May 6, 2026, at 10:14 AM, collectively revealed meals were frequently not served as posted on the menu and residents were not informed of last-minute menu changes. The residents further reported menu substitutions occurred almost daily. The residents stated that during the resident council meeting held on April 30, 2026, the dietary manager informed residents that some desserts were being removed from the menu due to budgetary constraints. A confidential staff interview conducted on May 7, 2026, at 11:20 AM, revealed some planned menu items for the Tuesday lunch meal were not received with the food order and required substitutions. The individual reported the facility did not receive German potato salad and substituted mashed potatoes. The individual further reported carrots and tropical fruit were unavailable and no additional items were available for substitution. The confidential interview also revealed the planned lunch meal for May 7, 2026, included a garlic bread stick and Prince [NAME] vegetable blend (a mixed vegetable blend consisting of carrots, wax beans, and green beans). However, garlic bread sticks were not received with the facility food order delivered on May 6, 2026, and were not substituted because insufficient items were available for replacement. The individual further reported the Prince [NAME] vegetable blend was unavailable and substituted with green beans. The individual stated weekly food<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | orders were reviewed by the corporate dietitian and food items were often not approved or were unavailable, resulting in menu items not being substituted and leaving the facility with limited replacement options. Review of the Week 2 menu posted on the second-floor bulletin board revealed the planned lunch meal for Thursday, May 7, 2026, included spaghetti and meatballs, Prince [NAME] vegetable blend, garlic bread stick, and assorted cookies. Observation of the lunch meal service on the second floor on May 7, 2026, at 12:55 PM, revealed resident trays did not include garlic bread sticks and green beans were served instead of the planned Prince [NAME] vegetable blend. Residents were not notified of the menu changes. Review of the facility's substitution logs for February 2026, March 2026, and April 2026, failed to reveal documentation that a Registered Dietitian reviewed substitutions for nutritional adequacy or signed off on substitutions made to the planned menu. An interview with the corporate Registered Dietitian on May 8, 2026, at 8:50 AM, revealed the dietary manager submitted weekly food orders through an electronic ordering system for review prior to final submission. The corporate RD stated she had no knowledge of menu items requiring substitution or omission. The above findings were reviewed with the corporate RD; however, no explanation was provided regarding why food items necessary to fulfill the planned menu were not available or why frequent substitutions occurred. The facility failed to provide documentation related to the dietary manager's submission of weekly food orders to the corporate Registered Dietitian. Review of the food order intended to fulfill Week 2 of the facility menu revealed food items necessary to prepare the posted menu were not ordered, substituted with nutritionally comparable items, or delivered by the food vendor. Missing or omitted food items included German potato salad, carrots, garlic bread sticks, and Prince [NAME] vegetable blend. During an interview with the Nursing Home Administrator (NHA) on May 8, 2026, at 11:00 AM, the above findings were reviewed and confirmed. Refer F801 Refer F 804 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.6 (a) Dietary services. 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 201.29(a) Resident rights. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observations, resident and staff interview, and test tray results, it was determined that the facility failed to ensure meals were served in a palatable and visually appealing manner and at safe and appetizing temperatures during in-room meal service for two test trays observed on the second and third floors during lunch meal service. (Residents 11, 15, 59, 60, 74, 76, 39, 30).Findings included: According to the federal regulatory guidance at 483.60(i)-(2) Food safety requirements - the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. An interview with Resident 39, on May 5, 2026, at 1:00 PM, a cognitively intact resident, stated the lunch meal served, consisting of kielbasa, mashed potatoes, and sauerkraut, included foods she disliked and reported that her food preferences were not consistently honored or routinely updated to meet her dietary preferences. Resident 39 further stated the meals served were frequently visually unappetizing and unpalatable. Observation of Resident 39's lunch tray on May 5, 2026, revealed the meal consisted primarily of white-colored food items served on a white plate. The planned chilled tropical fruit cup was not included on the tray. The color of the food blended into the plate and lacked visual appeal. In addition, excessive liquid from the sauerkraut spread across the plate and mixed into the mashed potatoes and kielbasa, resulting in an unappetizing appearance. Interviews conducted with six cognitively intact residents, Residents 11, 15, 59, 60, 74, and 76, on May 6, 2026, at 10:14 AM, revealed the residents collectively reported meals were frequently not served according to the posted menus and residents were not routinely informed of last-minute menu substitutions. The residents stated menu substitutions occurred almost daily. The residents further reported that during the resident council meeting conducted on April 30, 2026, the dietary manager informed residents that some desserts were being removed from the menu due to budgetary constraints. Observation of the second-floor lunch tray pass conducted on May 6, 2026, at 12:20 PM, revealed the first meal cart arrived on the unit at 12:23 PM, and staff immediately began distributing resident meal trays. The final tray was delivered at 12:39 PM. The final tray distributed, identified as Resident 30's tray, was removed from the meal cart for test tray sampling. Resident 30's lunch tray consisted of mashed sweet potatoes, chopped broccoli, mixed vegetables provided in accordance with the resident's preference for no meat items, and strawberry ice cream. Food temperature testing of Resident 30's tray revealed the mashed sweet potatoes were served at 126 degrees Fahrenheit, the chopped broccoli was served at 127 degrees Fahrenheit, and the mixed vegetables were served at 121 degrees Fahrenheit. The temperatures of the food items were below the federally recognized safe hot holding temperature of 135 degrees Fahrenheit. Taste testing of the sampled meal revealed the mashed sweet potatoes, chopped broccoli, and mixed vegetables were served lukewarm, unseasoned, bland, and unpalatable. Observation of the strawberry ice cream revealed the product was excessively melted and partially liquified at the time of service, resulting in an unappetizing consistency. The facility failed to ensure meals were served in a timely manner, at safe and appetizing temperatures, and in a visually appealing and palatable condition. During an interview conducted on May 6, 2026, at 2:00 PM, the Nursing Home Administrator confirmed the above observations. Refer F 803 28 Pa. Code 201.14(a)(b) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department and in one out of two resident nourishment room areas (second floor).Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy entitled Dating for Food Storage last reviewed by the facility on March 26, 2026, indicated bulk items were to be stored in approved containers with tight fitting lids with a label on the lid and side of container with the products name and date bin was filled. The facility's policy entitled Use and Storage of Food Brought in by Family or Visitors last reviewed by the facility on March 26, 2026, indicated the facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. All food items must be already prepared by the family or visitor, and food must be labeled with content and date. The prepared items brought into the facility must be consumed within three days. If not consumed within three days, food will be thrown away by facility staff. The initial tour of the dietary department conducted and confirmed with the facility's dietary manager on May 5, 2026, at 11:15 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: Upon entry of dietary department observed Employee 1, Dietary Aide, handing food service equipment without a beard guard to cover facial hair. Observations of the janitor's closet revealed a malodorous mildew smell and observed an uncovered storage bin full of soiled rags and wet mop heads. Observed the condenser fan, inside of the department's produce cooler, was corroded with ice crystals. The dietary manager reported that maintenance department was aware. However, the facility could not provide documented evidence of identifying ice corrosion covering the walk-in cooler prior to the surveyor's inspection. Observations inside of the dry storage room revealed flour stored in a bulk storage containing an ill-fitting lid that was exposing contents to environmental contaminants. Underneath the food storage shelving and perimeter of the storage room, observed debris and several deceased insects. Observations of the facility's second floor resident pantry area on May 5, 2026, at 12:15 PM, revealed inside of the resident freezer was an open gallon of chocolate ice cream covered in ice crystals and appeared to have melted and refrozen, that was not properly labeled or dated. Also, observed open cans of energy drinks left inside of the freezer. Observed the inside of the resident's refrigerator contained the following items that were opened and unlabeled: sticks of butter were discolored and deformed, a fast-food sandwich, a Styrofoam container of a red-orange liquid, five gallons of whole milk, and a sandwich. Additionally, the left wall had reddish-brown splatter running down the wall with a black colored substance with debris adhered along the perimeter of the room. A revisit to the dietary department on May 7, 2026, at 11:20 AM, revealed that multiple cases of food inside of the walk-in cooler, walk-in freezer, and dry storage area were left in direct contact with floor. An interview with a dietary staff member, who wished to remain anonymous, reported the food order arrived the day before but no staff were available to put it away and the dietary manager was busy tending to other kitchen duties. Interview with the Nursing Home Administrator (NHA) on May 8, 2026, at 2:00 PM, confirmed all food storage areas in the dietary department and resident nourishment room areas were to be maintained in a sanitary manner to ensure food safety. 28 Pa. Code 201.18 (e) (2.1) Management. 28 Pa. Code 211.6 (f) Dietary Services. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to maintain a clean, sanitary, functional, and comfortable environment on one of three resident floors reviewed, the first floor, which remained licensed and available for resident occupancy. Findings include: Observation on May 7, 2026, at 12:00 PM, revealed resident rooms 101 through 115, consisting of thirty-five licensed beds located on the facility's first floor, were unoccupied at the time of survey. However, these beds remained listed on the facility's state license and available for resident occupancy. Observations of the first-floor residents' rooms and bathrooms revealed the following: room [ROOM NUMBER] revealed a dirty floor with visible dirt, dust, and a large white stain in the corner of the room. Two mattresses were visibly dirty with brown stains. Several plastic electrical/light switch covers were broken, and metal screws were observed on the dresser. The toilet bowl contained brown and yellow staining. Dirty linens were observed on the floor. An open bottle of shampoo/body wash and loose metal screws were observed on the dresser. [NAME] liquid splatters were observed on the back of the door. room [ROOM NUMBER] contained three beds with ripped, dirty, and stained mattresses. No privacy curtains were present. Electrical and light switch outlet covers were missing. The floors contained visible dust, dirt, and liquid stains. The windows and windowsills contained dirt, liquid stains, and cobwebs. The air conditioning filter and unit cover contained visible lint, dirt, and rust. Dirty stained bath blankets were observed on the floor. The bathroom contained four dressers covered with heavy dust and dirt accumulation. Four large bulletin boards were stored in the room. The toilet contained brown and yellow staining. A ceiling tile contained a large brown stain. room [ROOM NUMBER] contained four beds with ripped, dirty, stained mattresses. A large hole was observed above the window. The windows and windowsills contained dirt, dust, and cobwebs. The air conditioning unit beneath the window contained heavy lint and accumulation of dirt. Open gaps measuring several inches were present on both sides of the air conditioning unit, exposing the room to the outside environment. The call bell system remained electrically connected but was hanging from the wall. No privacy curtains were present. Floors contained dirt, dust, and liquid stains. The bathroom floor contained visible dirt and dust accumulation, and the toilet contained brown and black staining. room [ROOM NUMBER] contained three beds with ripped and stained mattresses. No privacy curtains were present. The windows and windowsills contained dirt, dust, and cobwebs. Floors contained dirt, dust, and liquid stains. room [ROOM NUMBER] contained two beds with ripped mattresses and large brown stains. A dresser was missing drawers. No privacy curtains were present. Floors contained dirt and dust debris. Windows and windowsills contained dirt, dust, and cobwebs. The bathroom toilet contained brown staining. The toilet paper holder was detached from the wall. Two dressers in the bathroom contained exposed metal bolts. The sink, metal shelf beneath the mirror, and toilet contained numerous dead black insects. Multiple ceiling tiles above the toilet contained brown staining. Bathroom floors contained dirt, dust, and liquid stains. room [ROOM NUMBER] contained seven beds with ripped mattresses containing brown stains. Two dressers contained broken drawers. Floors contained dirt, dust, and fluid stains. Windows and windowsills contained dirt, dust, and cobwebs. Plastic outlet covers and metal screws were observed on the windowsill. Electrical and light outlets were exposed without protective covers. No privacy curtains were present. The bathroom toilet contained black and brown staining. Ceiling tiles above the toilet contained brown staining. A towel bar was observed on the floor and holes were present in the wall where the towel bar had been attached. Bathroom floors contained dirt, dust, and liquid stains. room [ROOM NUMBER] contained multiple dirty air mattresses on the floor. Four beds contained five additional piled dirty mattresses that were ripped and stained brown. Ten large bulletin boards were stored against the wall. Electrical and light switch outlets were uncovered and hanging from the wall. (continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Floors contained dirt, dust, and fluid stains. Windows contained dirt, dust, and cobwebs. Plastic outlet covers and metal screws were observed on the windowsill. Electrical outlets remained exposed without covers. No privacy curtains were present. room [ROOM NUMBER] contained five beds with ripped, dirty mattresses containing brown stains. Floors contained dirt, dust, and fluid stains. Windows contained dirt, dust, and cobwebs. Two garbage cans were stored on the windowsill. Electrical outlets remained exposed without covers. No privacy curtains were present. The bathroom floor contained dirt, dust, and liquid stains. Two dressers were stored in the bathroom. room [ROOM NUMBER] contained three beds without mattresses labeled bad. No privacy curtains were present. Floors contained dirt, dust, and liquid stains. Windows and windowsills contained dirt, dust, and cobwebs. Bathroom ceiling tiles above the sink and toilet contained brown staining, and three additional ceiling tiles also contained brown discoloration. The toilet bowl and toilet seat contained yellow and brown staining. room [ROOM NUMBER] contained six beds with multiple mattresses stacked on each bed. The mattresses were dirty and stained brown. Floors contained dirt, dust, and fluid stains. Windows contained dirt, dust, and cobwebs. Wall electrical outlet covers and light switch covers were missing. The bathroom floor contained dirt, dust, and liquid stains. Three bedside tables were stored in the bathroom with dirty linens, towels, and bath blankets on top. Metal screws and plastic outlet/light switch covers were observed on the bedside tables. The toilet contained brown and black staining. room [ROOM NUMBER] contained two beds with stained mattresses, two Geri-chairs (specialized reclining chairs commonly used for residents requiring supportive seating), and six wheelchairs. The beds were labeled broken. Floors contained dirt, dust, and fluid stains. Windows contained dirt, dust, and cobwebs. Four bathroom ceiling tiles contained large brown stains. room [ROOM NUMBER] contained a bed with a dirty air mattress, one Geri-chair, and seven wheelchairs. No window shades were present. [NAME] liquid stains were observed above the window extending down the wall and onto the window casings. The overbed table contained food and liquid stains. Windows and windowsills contained brown staining. No screen was present in the window. The bathroom floor contained dirt, dust, and liquid stains. Paper and brown staining were present in the toilet. room [ROOM NUMBER] contained two beds with dirty stained mattresses, five wheelchairs, and one Geri-chair. The shelf above the air conditioning unit contained dirt, liquid stains, lint, and cobwebs. Floors contained dirt, dust, and liquid stains. The bathroom floor contained dirt, dust, and liquid stains. Dirty stained linens were observed on the floor. The toilet contained brown and black staining. The sink and metal shelf above the sink contained liquid staining and dirt accumulation. room [ROOM NUMBER] contained two beds with stained mattresses. Floors contained dirt, dust, and liquid stains. room [ROOM NUMBER] contained three beds with dirty ripped mattresses. Floors contained dirt, dust, liquid stains, and debris. The garbage can was overflowing. The heating and air conditioning unit was removed, leaving the outside exposed to the room. The area contained heavy lint and dirt accumulation. The removed air conditioning cover contained heavy lint, dirt, and dust accumulation. The bathroom toilet lacked a toilet seat and contained a large brown and black stain. The sink was visibly dirty and stained. Bathroom floors contained dirt, dust, and liquid stains. Observation of the first-floor dining/activity room on May 7, 2026, revealed a window screen was missing while an on-site optometry clinic was being conducted in the room with five residents seated awaiting evaluation. During an interview on May 7, 2026, at 11:00 AM, the Nursing Home Administrator confirmed the above observations. The Administrator stated the first-floor beds had remained unoccupied for several years. The Administrator further confirmed the first-floor beds remained on the facility's state license and should be available for resident occupancy. 28 Pa Code 201.18(1)(3) Management. |

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| | 395273 | A. Building<br>B. Wing | 05/08/2026 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies, care plan documentation, and staff interviews, it was determined the facility failed to ensure comprehensive care plans were reviewed, revised, and discussed with residents and/or resident representatives following Minimum Data Set (MDS) assessments for three of 22 residents reviewed (Resident 4, Resident 9, and Resident 58). Findings include: The Resident Assessment Instrument (RAI) User's Manual, [DATE] edition, provides federal guidance for completion of the Minimum Data Set (MDS), a standardized assessment process used to identify resident needs and direct care planning. The manual requires facilities to develop a comprehensive care plan within seven days of completing the comprehensive MDS and to review and update the plan after each subsequent assessment. It also states that facilities must support resident participation in care planning by holding care plan conferences and giving residents and their representatives advance notice to ensure meaningful involvement. A review of the facility's policy, Care Planning -Resident Participation last reviewed [DATE]), revealed the facility's policy was to support each resident's right to participate in the care planning process. The policy indicated residents will be informed of their rights related to care planning and kept updated on their care and overall health. The policy specified that the facility would review the care plan with the resident or resident representative during scheduled meetings, at routine intervals, and whenever there is a significant change in condition. The facility will make reasonable efforts to schedule conferences at convenient times and will obtain a signature from the resident and/or representative after the care plan is discussed or reviewed. A review of the facility policy titled Comprehensive Care Plans, last reviewed [DATE], revealed a comprehensive, person-centered care plan would be developed and implemented for each resident. The policy indicated the interdisciplinary team (staff from different professional disciplines working together to coordinate resident care) would review and revise the care plan following quarterly and comprehensive MDS assessments to ensure interventions, goals, and target dates remained current and reflective of the resident's needs. Resident 4 was admitted to the facility on [DATE], with a diagnosis including non-active primary progressive multiple sclerosis (chronic condition when the neurological function steadily worsens over time and reflects ongoing nerve damage rather than intermittent inflammatory attacks). A review of Resident 4's quarterly MDS dated [DATE], revealed Resident 4 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a range of 13-15 indicated Resident 4 was cognitively intact). Review of Resident 4's clinical record revealed a quarterly MDS assessment was completed on February 1, 2026, and an annual MDS assessment was completed on [DATE]. Review of Resident 4's care plan revealed an active care plan addressing pain management with interventions including monitoring pain, notifying the physician if interventions were ineffective, and use of a left wrist brace (a supportive medical device intended to stabilize a body part). The care plan was initiated on [DATE], last revised on [DATE], and contained a target date (day by which the resident is expected to reach a goal in a person's care plan) of [DATE]. Review revealed a separate care plan addressing fall risk with interventions including maintaining the call bell within reach, keeping the bed in the lowest position, and completing neurological evaluations after unwitnessed falls. This care plan was initiated [DATE], revised [DATE], and also contained a target date of [DATE]. Review of the clinical record, including interdisciplinary progress notes, care plan documentation, and care conference documentation, revealed no evidence Resident 4's care plan was reviewed and/or revised following the February 1, 2026, quarterly MDS assessment or the [DATE], annual MDS assessment. The clinical record lacked evidence care plan conferences were conducted, lacked evidence Resident 4 and/or the resident representative participated in the care planning<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | process, and lacked evidence the resident and/or representative were invited to participate following completion of the assessments. The care plan target date of [DATE], had expired and was not updated. Resident 9 was admitted to the facility on [DATE], with a diagnosis of peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the legs and feet). A review of Resident 9's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating the resident was cognitively intact. Review of Resident 9's clinical record revealed quarterly MDS assessments were completed on [DATE], and [DATE]. Review of Resident 9's care plan revealed an active care plan addressing pain management with interventions including anticipating pain needs, responding timely to pain complaints, and evaluating the effectiveness of interventions. This care plan was initiated [DATE], last revised February 19, 2023, and contained a target date of [DATE]. A review revealed a separate care plan addressing Resident 9's fall risk with interventions including maintaining the call bell within reach, anticipating resident needs, use of appropriate footwear, therapy services, and neurological evaluations following unwitnessed falls. This care plan was initiated [DATE], revised [DATE], and also contained a target date of [DATE]. Review of the clinical record, including interdisciplinary progress notes, care plan documentation, and care conference documentation, revealed no evidence Resident 9's care plan was reviewed and/or revised following the [DATE], or [DATE], quarterly MDS assessments. The clinical record lacked evidence care plan conferences were conducted and lacked evidence Resident 9 and/or the resident representative participated in or were invited to participate in the care planning process following completion of the assessments. The target date of [DATE], was no longer current. Resident 58 was admitted to the facility on [DATE], with a diagnosis including chronic kidney disease (a condition in which the kidneys gradually lose the ability to effectively filter waste products from the blood) and dementia (a decline in memory and thinking abilities that affects daily functioning). A review of Resident 58's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, indicating the resident remained cognitively intact. Review of Resident 58's clinical record revealed quarterly MDS assessments were completed on [DATE], February 13, 2026, and [DATE]. Review of Resident 58's care plan revealed an active care plan addressing pain management with interventions including pain assessments, use of non-medication pain relief measures, monitoring pain using a pain scale, and evaluating intervention effectiveness. This care plan was initiated [DATE], last revised [DATE], and contained a target date of [DATE]. Review of Resident 58's clinical record revealed a separate care plan addressing fall risk with interventions including maintaining the call bell within reach, providing therapy services as needed, and ensuring use of non-slip footwear. This care plan was initiated [DATE], last revised [DATE], and contained a target date of [DATE]. Review of the clinical record, including interdisciplinary progress notes, care plan documentation, and care conference documentation, revealed no evidence Resident 58's care plan was reviewed and/or revised following the quarterly MDS assessments completed on [DATE], February 13, 2026, and [DATE]. The clinical record lacked evidence care plan conferences were conducted and lacked evidence Resident 58 and/or the resident representative participated in or were invited to participate in the care planning process following completion of the assessments. The care plan target date of [DATE], expired and was not updated. Review of the clinical records for Resident 4, Resident 9, and Resident 58 lacked evidence of routine interdisciplinary review of the comprehensive care plans, lacked evidence of ongoing resident-centered revisions following MDS assessments, and lacked evidence of documented efforts to involve residents and/or resident representatives in the care planning process as required by the RAI Manual and facility policy. During an interview conducted on [DATE], at 08:45 AM, the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON) confirmed care plan conferences were not conducted for Resident 4, Resident 9, and Resident 58 and acknowledged the care plans were not routinely reviewed and/or revised following MDS assessments. During an interview conducted on [DATE], at 11:00 AM, the Registered Nurse Assessment Coordinator (RNAC) acknowledged care plan conferences were not held for Resident 4, Resident 9, and Resident 58 and (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | could not provide evidence the residents and/or resident representatives were invited to participate in the care planning process. The RNAC acknowledged the care plans were not routinely reviewed and/or revised following quarterly and annual MDS assessments as required by the RAI Manual and facility policy. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12(d)(3) Nursing services. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, weight records, nutritional documentation, and staff interviews, it was determined the facility failed to consistently monitor resident weights, ensure accurate and timely weight tracking, and timely implement nutritional interventions to address significant weight loss for two (2) of twenty-two (22) residents reviewed (Residents 30 and 5).Findings include: A review of a facility policy entitled Weight Policy last reviewed by the facility on March 26, 2026, indicated resident weights will be obtained in a timely and accurate manner, documented and responded to appropriately. The Registered Dietitian (RD) will be notified of significant changes in weights, insidious weight loss, and other concerns related to diet and intake. Acute or chronic weight changes will be documented, and recommendations will be provided by the dietitian as appropriate. The dietitian will track weights and will review the ongoing monthly weights to determine if there has been a significant weight loss greater than 5 percent in one month, 7.5 percent in three months, or 10 percent in six months. The dietitian will work with the facility staff during the routine weight meeting to review resident weight trends and determine any additional interventions for the resident's weight change. A clinical record review revealed Resident 30 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills and characterized by a loss of cognitive functioning such as thinking, remembering, and reasoning that interfere with a person's daily life and activities), major depressive disorder ( mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a disorder that presents with intense, excessive and persistent worry and fear about everyday situations and often involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes resulting in panic attacks). A review of the Resident 30's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 11, 2026, revealed that Resident 30 had severe cognitive impairment with a BIMS score of 4 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment) indicating severe cognitive impairment, and required staff set-up assistance for meals. Review of Resident 30's care plan revealed a nutrition-at-risk care plan initiated on May 12, 2025, and last revised on December 26, 2025, identified the resident was at risk for nutritional problems related to hypertension (high blood pressure), history of cervical cancer, Alzheimer's disease, and significant unplanned weight loss. The resident goal was to maintain adequate nutritional status as evidenced by maintaining weight within five percent of CBW (current body weight), no signs or symptoms of malnutrition, and consuming at least 50 percent of at least 2 meals daily. Interventions included honoring food preferences, encouraging oral intake, offering meal alternatives when less than 50 percent of meals were consumed, obtaining weights as ordered, and RD monitoring and evaluation. Clinical record review revealed a weight change progress note completed by Employee 12, the facility's former RD, dated March 24, 2026, at 2:04 PM, documented Resident 30 weighed 111.3 pounds on March 22, 2026, and had experienced a significant weight loss of 10.9 pounds or 7.5 percent over ninety days. The note identified suboptimal oral intake and documented the resident received bedtime nutritional shakes three times daily and Magic Cup (a high-calorie, high-protein frozen nutritional supplement) daily. The note further documented the resident received Mirtazapine (a medication used for depression that may also stimulate appetite), recently increased to 15 milligrams. Resident 30's BMI (Body Mass Index, a measurement based on height and weight used to determine whether a person is within a healthy weight range) remained within normal limits; however, the BMI was noted to be low for advanced age. No pressure ulcers (also known as bedsores, skin wounds caused by prolonged<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | pressure to the skin) or edema (swelling caused by fluid buildup) were noted at the time of assessment. Recommendations included honoring food preferences, offering meal alternatives when the resident consumed less than 50 percent of meals, monitoring weekly weights, and continuing to monitor and update nutritional interventions as warranted. Review of Resident 30's weight records revealed the following documented weights:March 29, 2026, at 1:36 AM: 112.7 poundsApril 5, 2026, at 11:00 AM: 113 poundsApril 12, 2026, at 9:28 AM: 101.2 pounds These documented weights reflected a weight loss of 11.8 pounds or 10.4 percent within one week. Review of a subsequent RD progress note completed by former facility RD, Employee 12 on April 17, 2026, at 2:12 PM, five days after the significant weight loss occurred, documented Resident 30 triggered for significant weight loss of 11.8 pounds or 10.4 percent in one week. The note indicated a reweigh was requested due to questionable inconsistencies in weekly weights. The note further documented the resident demonstrated poor oral intake, increased dependence on staff during meals, acceptance of ordered nutritional supplements, and a recent urinary tract infection (UTI, an infection involving the urinary system) that may have affected appetite. Recommendations included increasing Magic Cup twice daily and reassessing after a reweigh was obtained. Review of Resident 30's meal intake documentation for April 2026 revealed staff failed to consistently document meal intake percentages. Out of ninety (90) meal opportunities reviewed, staff failed to document meal intake thirty-four (34) times, representing thirty-eight percent of opportunities reviewed. Of the documented meal intakes, staff documented the resident consumed between zero and twenty-five percent of meals during twenty-two percent of observations. A review of the resident's survey documentation report (an electronic record of completed nurse aide tasks, including meal intake percentages) for April 2026 revealed staff failed to consistently document Resident 30's meal intake percentages. Out of ninety (90) meal opportunities reviewed, staff failed to record meal consumption thirty-four (34) times, representing thirty-eight percent of opportunities. Of the documented meal intakes, staff recorded the resident consumed zero to twenty-five percent of meals during twenty (20) observations, representing twenty-two percent of meal opportunities reviewed. Staff documented meal consumption of twenty-six to fifty percent during eighteen (18) observations, representing twenty percent of opportunities reviewed, and documented meal consumption of fifty-one to seventy-six percent during eighteen (18) observations, also representing twenty percent of opportunities reviewed. A review of Resident 30's clinical record revealed the requested reweigh was not completed and no additional weekly weights were obtained until May 3, 2026. The facility failed to timely respond to Resident 30's significant weight loss from April 5, 2026, to April 12, 2026, failed to obtain requested reweighs and weekly weights, and failed to ensure consistent meal intake documentation necessary to accurately monitor the resident's nutritional status and implement timely interventions. A clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses that included dysphasia (difficulty swallowing), generalized anxiety disorder, and heart failure (occurs when the heart muscle doesn't pump blood as well as it should and the blood often backs up and fluid can build up in the lungs, causing shortness of breath). A review of the resident's admission/5-day Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 5 was cognitively intact with a BIMS score of 15(a score of 12-15 indicates no cognitive impairment or intact cognition) and required staff set-up assistance for meals. Clinical record review revealed Employee 12, former RD, completed a medical nutrition and hydration evaluation for Resident 5 on November 18, 2025, at 3:43 PM, signed November 25, 2025, at 1:26 PM. The assessment documented the resident received a regular diet with mechanical soft texture (foods modified to be soft and easier to chew and swallow) and thin liquids. The assessment further documented supplementation with Boost (a high-calorie, high-protein oral nutritional supplement) daily and Liquacel (a concentrated liquid protein supplement) twice daily. The RD assessment noted the resident had fair appetite with meal intake generally between 50 and 75 percent, required staff set-up assistance, and weighed 105.6 pounds with a Body Mass Index (BMI) of 19.3, which was noted to be low for advanced age. The resident was identified as being at risk for protein-calorie malnutrition due (continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | to moderate muscle and fat loss. Weekly weights were requested. Review of physician orders revealed the ordered nutritional supplements identified in the RD assessment were not implemented at the time of the assessment. Orders for Boost Plus were not initiated until November 19, 2025, at 9:00 AM, and Liquacel was not initiated until November 24, 2025, at 7:00 PM. Review of Resident 5's weight records revealed the following documented weights: November 23, 2025, at 10:23 AM: 108.9 poundsNovember 23, 2025, at 1:51 PM: 99.6 pounds, later stricken by Employee 12 on December 5, 2025December 3, 2025, at 6:19 PM: 106 poundsDecember 7, 2025, at 1:47 PM: 105.8 poundsJanuary 9, 2026, at 11:47 AM: 108 poundsFebruary 5, 2026, at 7:14 AM: 91 poundsMarch 11, 2026, at 2:31 PM: 90.6 pounds Review of a quarterly medical nutrition therapy progress note completed by Employee 14, interim RD, initiated February 9, 2026, at 2:44 PM, and signed February 13, 2026, at 12:44 PM, documented Resident 5 experienced a significant weight loss of 15.7 percent within thirty days. The note identified the resident's BMI was 16.6, placing the resident in the underweight range, and recommended adding Magic Cup three times daily. Review of a quarterly medical nutrition therapy progress note completed by Employee 14, interim RD, initiated February 9, 2026, at 2:44 PM, and signed February 13, 2026, at 12:44 PM, documented Resident 5 experienced a significant weight loss of 15.7 percent within thirty days. The note identified the resident's BMI was 16.6, placing the resident in the underweight range, and recommended adding Magic Cup three times daily. Review of physician orders revealed the order for Magic Cup three times daily was not initiated until February 13, 2026, at 4:00 PM, seven days after the significant weight loss occurred on February 5, 2026. Clinical record review revealed no additional nutritional monitoring documentation was completed after the RD documented the significant weight loss, and no additional weights were recorded after March 11, 2026, when the resident weighed 90.6 pounds. The facility failed to timely reassess and implement nutritional interventions following Resident 5's significant weight loss and failed to conduct ongoing monitoring of the resident's nutritional status and weight trends. During an interview on May 7, 2026, at 1:30 PM, the Nursing Home Administrator confirmed Employee 12 had been on leave for several months and Employee 14 served as the covering RD during that period. The above findings were reviewed with and confirmed by the Nursing Home Administrator. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, select facility policy review, and staff interviews, it was determined the facility failed to implement and adhere to procedures to ensure acceptable storage and use-by dates for multi-dose medications in two of two medication rooms (Second floor medication room and third floor medication room).Findings include: A review of the facility policy titled Medication Storage, last reviewed March 26, 2026, indicated the facility required medications and biologicals (treatments made from living cells) to be stored safely, securely, and according to manufacturer recommendations. The procedure also stated that outdated medications were to be removed from stock immediately, disposed of per medication destruction procedures, and reordered from the pharmacy. Review of the policy titled Medication Disposal and Returns, Dating and Discarding of Multidose Parenteral Vials last reviewed on March 26, 2026, indicated that nursing staff will date multidose vials (containers of medication intended for use more than one time) and discard opened vials to decrease the risk of contamination and bacterial or fungal growth from multidose vials. Specifically, nursing staff shall date the vial when first entered and the vial should be discarded within 28 days unless otherwise indicated. Nursing staff is responsible for inspecting medications and the expiration date on a regular basis and expired drugs should be discarded per procedure according to the policy. An observation of the Third Floor Medication Room on May 7, 2026, at 12:52 PM, in the presence of Employee 2, Licensed Practical Nurse (LPN), revealed the following expired medications stored in the medication room. Two clear plastic medication containers containing intravenous (IV, administered through a vein) medication labeled IV Meropenem 1 gram (gm)/1 milliliter (mL) (antibiotic used to treat serious bacterial infections) in IV Sodium Chloride 0.9% 90 milliliters and 10 mL sterile water, with a use-by date of April 27, 2026. One bottle of Omeprazole Suspension 2 milligrams (mg)/mL (medication used to reduce stomach acid and treat conditions such as acid reflux or ulcers) with an expiration date of April 25, 2026. One bottle of Omeprazole Suspension 2 mg/mL with an expiration date of April 9, 2026. An interview with Employee 2, LPN, on May 7, 2026, at 1:00 PM confirmed the IV medications and Omeprazole bottles were expired and remained stored in the medication room available for resident use. An observation of the Second Floor Medication Room on May 7, 2026, at 1:14 PM, in the presence of Employee 3, Registered Nurse (RN), revealed the following: One opened vial of Tuberculin Purified Protein Derivative Diluted Aplisol (solution used during tuberculosis (TB) skin testing to determine exposure to TB bacteria) with no date present indicating when the vial was first opened. One opened vial of Insulin Lispro Injection (a rapid-acting insulin used to control blood sugar levels in individuals with diabetes) with no date present indicating when the vial was first opened. Five Aptima Unisex Swab specimen collection devices, (used to collect laboratory samples), with an expiration date of April 30, 2026. Two Universal Viral Transport collection devices, (used to transport body fluid specimens to a laboratory for testing of viruses and other microorganisms), with an expiration date of January 24, 2026. During an interview on May 7, 2026, at 1:44 PM, the Nursing Home Administrator and Employee 4, Registered Nurse, Corporate Director of Nursing, reviewed and acknowledged the above findings related to the facility's failure to adhere to acceptable medication and biological storage practices, including required labeling, monitoring, and removal of expired medications and supplies from use. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on a review of select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide snacks as desired by residents, including experiences reported by four of six residents participating in a group interview (Residents 15, 11, 59, and 74).Findings include: A review of the facility policy titled Snacks, last reviewed by the facility on March 26, 2026, revealed it is the facility policy that bedtime (HS- hour of sleep) snacks will be provided for all residents. Additionally, diabetic residents are required to have a nourishing snack consisting of two food groups. During a resident group interview on May 6, 2026, at 10:00 AM, four of six residents in attendance (Residents 15, 11, 59, and 74) stated that snacks are not routinely offered to them in the evenings, and they would like to receive an evening or bedtime snack. These four residents stated they have brought these concerns up during multiple resident council meetings and this is an ongoing concern. Residents 59 and 74 stated that the dietary department bring up the snacks to the unit, but nursing staff do not deliver them to residents, and not all residents know that the snacks are available at the nurses station. Review of grievances for the last six months revealed no documented grievances regarding snacks. During an interview on May 7, 2026, at approximately 1:30 PM, the Nursing Home Administrator (NHA) was unable to explain why residents were not consistently offered snacks as desired. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on review of facility policy, observation, and staff interview, it was determined the facility failed to maintain the privacy and confidentiality of residents' medical information and treatment during dental examinations on one of three clinical environments reviewed (Resident 12, Resident 28, and Resident 47). Findings include: Review of facility policy HIPAA Security Measures, (Health Insurance Portability and Accountability Act, a federal law enacted to protect the privacy and security of individuals' health information) last reviewed March 26, 2026, indicated it is the policy of the facility to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of resident's identifiable information and records. Review of the document titled Notice of Rights of Nursing Facility Residents revealed residents are entitled to privacy regarding their medical treatment, written and verbal communication, and visits or meetings with family and resident groups. This document was provided to all residents as part of the facility's admission information. An observation on May 5, 2026, at 12:09 PM in the first floor dining room revealed nine residents were seated in the rear of the room while Employee 5, Dentist, conducted dental examinations at the front of the room. The dental assistant was observed seated at a computer station with the computer screen visible to individuals present in the room. Employee 5, Dentist and the dental assistant were observed discussing resident-specific health information in the presence of the nine residents waiting for examination. Facility staff were observed escorting residents into the room and discussing resident health information with Employee 5, Dentist, in the presence of the other residents awaiting treatment. Observation further revealed no curtain, partition, privacy screen, or other barrier separating the resident receiving the dental examination from the remaining residents in the room. An interview conducted on May 5, 2026, with Employee 5 confirmed dental examinations were conducted in the dining room without a physical barrier or privacy measure separating the resident being examined from the other residents waiting in the room. Further interview with the Nursing Home Administrator on May 5, 2026, revealed Residents 12, 28, and 47 had already undergone dental examinations in this manner prior to the 12:09 PM observation. During an interview on May 5, 2026, Employee 5 and the Nursing Home Administrator acknowledged the facility failed to maintain the confidentiality and privacy of residents' health information and treatment during the dental examinations conducted on one of the facility's three clinical environments. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. code: 211.5(b) Medical records. 28 Pa. Code: 211.12(d)(1) Nursing services. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility investigative documentation, clinical records, hospital records, and staff interviews, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure licensed nursing staff timely assessed, monitored, evaluated, documented, and responded to a resident's condition following a witnessed fall event for one (1) of twenty-two (22) sampled residents reviewed (Resident 91). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care. Nurses are responsible to timely document assessments, clinical problems, changes in condition, and communications regarding resident care in order to support continuity of care and informed clinical decision making. A review of the clinical record revealed Resident 91 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills) and lower leg deep vein thrombosis (blood clots). A review of Resident 91's discharge Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 29, 2026, Resident 91 was severely cognitively impaired and required staff assistance for transfers and ambulation. A review of a care plan related to activities of daily living, dated December 31, 2025, revealed the resident required assistance of one staff person for ambulation. This intervention was dated as January 5, 2026. A review of a care plan related to falls revealed interventions were implemented to prevent falls and maintain the resident as free from falls as possible. A review of physician orders dated December 30, 2025, revealed an order for Enoxaparin Sodium (Lovenox, a blood thinning medication used to reduce blood clotting), 100 milligrams administered subcutaneously (under the skin) twice daily. Physician orders dated February 11, 2026, revealed the medication was to continue for three months. A review of medication administration records (MAR) dated December 30, 2025, through March 27, 2026, indicated that Resident 91 received the injectable blood thinning medication daily as prescribed by the Physician. A review of facility investigative documentation dated March 30, 2026, revealed that on March 27, 2026, at 1:30 PM, Resident 91 was standing near the window in the second floor activity room when he fell into a reclining chair and then slid to the floor landing on his bottom. The documentation indicated the resident did not hit his head. The fall was witnessed by the activity director and residents in the activity room. The investigation documentation was completed three days after the incident by the former Director of Nursing. A review of a witness statement completed by the Activity Director and dated March 30, 2026, revealed Resident 91 became increasingly agitated while standing near the activity room window, shifted to the left, slid into a Broda chair (a reclining positioning chair designed<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to support residents), which broke his fall, and then slid to the floor. The Activity Director documented that she called nursing staff for assistance. The facility was unable to provide additional witness statements, nursing assessments, neurological assessments, pain assessments, monitoring documentation, post-fall evaluations, nursing progress notes, or documentation identifying which nursing staff responded after the incident. During an interview on May 7, 2026, at 1:00 PM, the Activity Director stated she was supervising approximately eleven residents during an activity at the time of the incident on March 27, 2026. She stated Resident 91 had been standing near the activity room window, appeared agitated, and his knees appeared to give out. She indicated there were several wheelchairs and Geri -chairs (a high back reclining chair used for positioning and comfort) stored in this area. She stated the resident struck his abdominal area on the seat of a Geri chair prior to sliding to the floor. The activity director stated that there were 11 residents that she was supervising with an activity at tables in the room at the time of the fall. She confirmed that the wheelchairs and Geri chairs were stored under the windows because there was no place to put them. The activity director conducted a demonstration of the resident's fall for this surveyor, confirming that his abdominal area fell into the chair seat prior to sliding to the floor. The activity director then called nursing to report the incident. She stated that they removed Resident 91 from the area to his room. The activity director could not identify which nursing staff responded to her call and removed the resident. A review of nursing documentation dated March 29, 2026, at 10:00 PM, revealed the resident's wife observed bruising and swelling to the resident's abdomen and reported the resident complained of abdominal pain. Documentation revealed the physician was notified at that time and ordered transfer to the emergency department for evaluation. The resident was transferred to the hospital at approximately 10:10 PM on March 29, 2026, more than two days after the witnessed fall incident. A review of hospital documentation dated March 29, 2026, revealed Resident 91 presented to the emergency department accompanied by his wife for evaluation of altered mental status (a change in mental functioning that may include confusion, decreased responsiveness, or inability to appropriately respond). Hospital documentation indicated the medical history was provided by the resident's wife. According to the hospital documentation, the wife reported that upon visiting the resident at the facility, she found him mentally altered and not responding to questions. The hospital documentation further indicated that facility staff informed the wife that the resident had not slept for the previous two days and was tired. The hospital documentation revealed the wife observed the resident holding his abdomen, screaming in pain when moved from the bed to the chair, and experiencing abdominal swelling, which prompted her request for transfer to the emergency department. The hospital documentation further revealed the wife reported concerns that the resident may have experienced a fall at the facility. Laboratory results obtained at the hospital revealed a hemoglobin level of 11 grams per deciliter. (Hemoglobin is a protein in red blood cells responsible for carrying oxygen throughout the body, and decreased levels may indicate blood loss. The normal reference range for adult males is approximately 14 to 18 grams per deciliter). A review of hospital documentation revealed a CT (computed tomography, a diagnostic imaging test using X-rays to create detailed internal body images) scan of the chest and abdomen was ordered and completed on March 30, 2026. The CT scan results revealed a large left rectus sheath hematoma (a collection of blood within the abdominal muscle wall) with suspected active extravasation (active bleeding leaking from a blood vessel) within the lower portion of the hematoma from a branch of the left inferior epigastric artery (a blood vessel supplying the lower abdominal wall). The documentation further revealed extraperitoneal spread of the hematoma into the anterior pelvis (bleeding extending outside the abdominal cavity into the front pelvic area). Hospital documentation noted that in the absence of known trauma, the bleeding was believed to be spontaneous and likely associated with anticoagulation therapy (blood thinning medication use). Review of physician orders revealed the resident received Enoxaparin Sodium (Lovenox), an anticoagulant medication used to reduce blood clotting. A review of hospital documentation revealed the resident was evaluated by the trauma<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | surgery team for acute surgical intervention. Hospital documentation revealed the resident underwent embolization (a minimally invasive procedure used to block a bleeding blood vessel) of the left inferior epigastric artery on March 30, 2026, utilizing Gel foam and coil embolization materials to stop the bleeding. The resident did not return to the facility following hospitalization. Despite a witnessed fall event on March 27, 2026, involving abdominal impact and the resident's known anticoagulant use, the facility failed to ensure licensed nursing staff completed and documented a timely nursing assessment, evaluation, monitoring, or ongoing observation of the resident's condition following the incident. The facility failed to ensure nursing staff identified, evaluated, and responded to signs and symptoms consistent with potential internal bleeding until the resident's wife identified abdominal swelling, bruising, pain, and altered mental status approximately two days later on March 29, 2026. During an interview on May 6, 2026, at approximately 12:00 PM, the Director of Nursing stated she had no prior knowledge of the incident because the former Director of Nursing completed the investigation related to the fall event. The Director of Nursing stated the facility could not provide additional witness statements, documentation of post-fall monitoring, or documentation identifying which nursing staff responded to or assessed the resident following the incident. Review of the clinical record and facility investigative documentation failed to reveal documentation of a timely nursing assessment, evaluation, or ongoing monitoring completed after the resident's fall. The Director of Nursing acknowledged the resident's anticoagulant medication use may have increased his risk for bleeding complications following trauma. 28 Pa. Code 211.5 (f) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, it was determined the facility failed to ensure a resident received necessary assistive devices and assistance to maintain vision abilities for one of 22 residents reviewed (Resident 28).Findings include: Review of Resident 28's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, (a mental health disorder characterized by significant mood changes, including periods of depression and periods of elevated or irritable mood). During an interview on May 5, 2026, at 12:30 PM, Resident 28 asked the surveyor if she worked for the eye doctor and stated he had been waiting a long time for his glasses. Resident 28 stated he could not see well without glasses and did not have any. Observation of the resident and the resident's room at that time revealed no glasses were present. Review of the resident's clinical record revealed an eye consult dated January 19, 2026, which indicated the resident required glasses and documented that glasses were to be ordered. Review of the clinical record revealed no documented evidence that the glasses had been ordered as of May 6, 2026. Review of outside psychiatric consultation documentation dated February 27, 2026, through May 1, 2026, revealed the resident repeatedly expressed concerns regarding not having glasses and the impact the lack of glasses had on his mood and well-being. Review of the psychiatric consult dated February 27, 2026, revealed Resident 28 informed the consultant social worker he was concerned about waiting for his glasses. The consult documented the consultant social worker asked the Director of Nursing (DON) about the resident's glasses and the DON stated she had no knowledge regarding the glasses. Review of the psychiatric consult dated March 27, 2026, revealed the resident continued to voice concerns regarding not having glasses. Review of the psychiatric consult dated May 1, 2026, revealed the resident again expressed concern regarding the continued lack of glasses. The psychiatric consultation documentation indicated that the resident's depression was negatively affected by the absence of the prescribed glasses. During an interview on May 6, 2026, at 2:30 PM, the Nursing Home Administrator (NHA) stated the glasses were not ordered because the resident reportedly had an unpaid bill for previous glasses. The NHA was unable to provide documented evidence the glasses had been ordered, documented evidence of an outstanding bill for prior glasses, or documented evidence the facility assisted the resident in obtaining the prescribed glasses. During a follow-up interview on May 8, 2026, at 9:46 AM, the NHA confirmed there was no documented evidence that the resident's glasses had been ordered and no documented evidence the facility provided assistance to Resident 28 in obtaining the prescribed glasses. 28 Pa code 211.12(d)(5) Nursing Services. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policy, and staff interviews, it was determined the facility failed to consistently implement a planned restorative nursing program to maintain mobility and functional abilities to the extent possible for one of 22 residents reviewed (Resident 5). Findings include: A review of the facility policy titled Restorative Nursing Services, last reviewed by the facility on March 26, 2026, revealed residents are typically referred to restorative nursing services by therapy staff and nursing staff evaluate the resident's physical and medical capabilities within 72 hours of referral. A review of the clinical record revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric fracture of the right femur (a severe hip fracture occurring between the upper portions of the thigh bone near the hip joint in which the broken bone fragments are separated and commonly require surgical repair with hardware such as rods, plates, or screws). A review of Resident 5's Quarterly Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 18, 2026, revealed the resident required substantial to maximal assistance with lower extremity mobility and activities of daily living. A review of physical therapy discharge recommendations dated January 7, 2026, revealed therapy recommended Resident 5 receive restorative nursing services consisting of passive range of motion (movement of joints performed by another person without the resident actively assisting) and active assistive range of motion exercises (exercises in which the resident participates in movement with assistance from another individual to bilateral (both) lower extremities for 20 repetitions. A review of Resident 5's comprehensive care plan in effect through the survey end date of May 8, 2026, revealed the resident had an activities of daily living self-care performance deficit related to decreased mobility and required staff assistance. Review of the care plan revealed no evidence the resident's restorative nursing program was included in the resident-centered plan of care. A review of Resident 5's task report (an electronic record that summarized planned resident-centered tasks completed by nursing) and Documentation Survey Report v2 (care tasks completed for the resident) for April and May 2026 revealed no documented evidence staff implemented the resident's ordered restorative nursing program. Review of the clinical record revealed no documented evidence licensed nursing staff identified, monitored, or addressed that the restorative nursing program was not being implemented as recommended following therapy discharge. During an interview on May 7, 2026, at 1:00 PM, the Director of Nursing reviewed the above findings and acknowledged the facility could not provide evidence that the restorative nursing program for Resident 5 had been consistently implemented to maintain the resident's mobility and functional abilities to the extent possible. 28 Pa Code 211.10 (d) Resident care policies. 28 Pa Code 211.12(c)(d)(5) Nursing services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it was determined the facility failed to maintain an environment free from accident hazards related to unsafe electrical connections and improper use of extension cords and power strips for resident care equipment and electrical devices in three resident rooms reviewed (Rooms 321 Bed 2, 308 Bed 2, and 306 Bed B).Findings include: During an observation on May 5, 2026, at 10:00 AM in room [ROOM NUMBER] Bed 2, the room window was observed open without a screen in place. No air conditioning unit was present in the window. A standing fan was positioned in front of the open window blowing air into the room. Observation revealed the standing fan, resident bed, nebulizer machine (a machine used to administer breathing treatments), and television were plugged into a multi-outlet power strip. The power strip was connected to an extension cord, which was then plugged into the wall electrical outlet. In addition, a tube feeding pump (an electrical medical device used to deliver liquid nutrition through a feeding tube) was plugged into a separate extension cord running underneath the resident's bed and connected into the same power strip arrangement. Multiple electrical devices and resident care equipment were connected through chained extension cords and power strips rather than directly into permanent wall electrical outlets. The use of multiple extension cords and power strips for resident care equipment created the potential electrical accidents and tripping hazards from electrical cords running through the resident care area. During an observation on May 6, 2026, at 1:00 PM in room [ROOM NUMBER] Bed 2, a CPAP machine (Continuous Positive Airway Pressure machine used to assist breathing during sleep) was observed plugged into a power strip extension cord rather than directly into a wall electrical outlet. During an observation on May 6, 2026, at 1:15 PM in room [ROOM NUMBER] Bed B, an electric wheelchair charger was observed plugged into an extension cord connected to the wall electrical outlet. During an interview on May 6, 2026, at 2:00 PM, the Nursing Home Administrator confirmed the above observations. 28 Pa. Code 201.18 (b)(1)(3) Management. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, nutritional documentation, observations, and staff interviews, it was determined that the facility failed to provide care and services for a resident receiving enteral nutrition (nutrition provided through a feeding tube) to prevent significant weight loss and ensure adequate nutritional support for 1 of 1 resident reviewed for feeding tube management (Resident 10). Findings include: A review of the facility policy titled Care and Treatment of Feeding Tubes, last reviewed by the facility on March 26, 2026, revealed it was the policy of the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The policy indicated periodic evaluation of the amount of feeding administered for consistency with practitioner orders and stated that nutrition staff would determine whether tube feedings met residents' nutritional needs and adjust feedings accordingly. Review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included traumatic brain injury, dysphagia (difficulty swallowing) and a gastrostomy tube (a feeding tube inserted directly into the stomach for nutrition, fluids, and medications). A review of the resident's quarterly Minimum Data Set (MDS, a federally required standardized resident assessment used for care planning) dated April 3, 2026, revealed the resident was severely cognitively impaired and dependent on a feeding tube for nutritional support. The assessment indicated the resident was 5 feet tall and weighed 99 pounds.Review of physician orders revealed the resident had an order for DiabetiSource tube feeding solution at 68.5 milliliters per hour (mL/hr) continuously over 24 hours through a PEG tube (Percutaneous Endoscopic Gastrostomy tube, a feeding tube inserted directly into the stomach through the abdominal wall). The resident also had an order for water flushes of 120 milliliters (mL) every 4 hours during tube feeding infusion.Review of physician orders dated June 7, 2025, revealed nursing staff were instructed to check placement and residual of the PEG tube prior to medication administration and feedings. Gastric residual (the amount of fluid and feeding formula remaining in the stomach during enteral feeding) is checked to evaluate feeding tolerance and reduce the risk of complications associated with delayed stomach emptying or overfilling of the stomach.There was no clarification in the clinical record regarding the start times of the resident's continuous tube feeding despite the feeding being ordered over a continuous 24-hour period daily. In addition, the physician order failed to identify a residual amount at which nursing staff were to hold the tube feeding or notify the physician. There was no documented evidence at the time of the survey that the facility clarified these orders for Resident 10.A review of the March 2026 through May 2026 Medication Administration Records (MARs) revealed nursing staff documented varying gastric residual amounts, including:March 6, 2026, day shift: 25 cubic centimeters (cc)March 9, 2026, day shift: 60 ccMarch 13, 2026, day shift: 25 ccMarch 17, 2026, day shift: 20 cc; evening shift: 20 ccMarch 18, 2026, day shift: 25 ccMarch 20, 2026, evening shift: 50 ccMarch 26, 2026, day shift: 170 ccMarch 27, 2026, day shift: 60 ccApril 15, 2026, day shift: 60 ccApril 16, 2026, day shift: 60 ccApril 17, 2026, day shift: 10 cc; evening shift: 10 cc; night shift: 10 ccApril 18, 2026, day shift: 30 ccApril 20, 2026, day shift: 60 cc; evening shift: 60 ccApril 23, 2026, day shift: 40 ccApril 29, 2026, day shift: 40 cc; evening shift: 40 cc; night shift: 40 ccApril 30, 2026, day shift: 150 cc; evening shift: 150 ccMay 6, 2026, day shift: 60 cc; evening shift: 60 cc; night shift: 60 ccReview of the clinical record revealed there was no physician order identifying the gastric residual amount requiring tube feeding interruption, physician notification, additional monitoring, or further clinical intervention A review of the resident's care plan for tube feeding, initially dated September 21, 2023, and revised July 4, 2024, revealed goals for the resident to tolerate tube feeding and maintain nutritional status. Interventions included Registered Dietitian (RD) evaluation quarterly and as needed, monitoring caloric intake, establishing nutritional needs, and making recommendations for tube<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | feeding changes as necessary. Review of documented weights revealed the following:March 29, 2026: 99 poundsApril 19, 2026: 90 poundsThese weights reflected a 9-pound weight loss or 9.09 percent body weight loss within 3 weeks. A review of Medication Administration Records dated March 1 through March 31, 2026, April 1 through April 30, 2026, and May 1 through May 6, 2026, revealed nursing staff documented tube feeding administration using check marks only. The MARs contained no documented amounts of tube feeding infused per shift and no documented 24-hour totals to determine the actual volume of nutrition received by the resident.During an observation on May 5, 2026, at approximately 9:00 AM, Resident 10 was observed in the first-floor dining/activity room awaiting an ophthalmology appointments with the tube feeding disconnected (not receiving ordered nutrition and fluids through the feeding tube at that time). Continued observations throughout the morning revealed the resident remained off the feeding pump. At approximately 12:00 PM, the resident had not returned to her room. At approximately 12:30 PM, the resident was observed back in her room with the tube feeding reconnected. During an observation on May 6, 2026, at 9:00 AM, Resident 10 was observed lying in bed with the tube feeding disconnected. A second observation on May 6, 2026, at approximately 12:15 PM, revealed the resident remained in bed with the tube feeding disconnected. During an interview on May 6, 2026, at approximately 12:15 PM, Employee 13, Licensed Practical Nurse (LPN), stated she checked the resident's gastric residual (the amount of feeding formula remaining in the stomach during tube feeding). Employee 13 stated that if the gastric residual exceeded the amount ordered by the physician, nursing staff would hold the tube feeding and notify the physician. Employee 13 stated the resident's residual was elevated and the tube feeding pump was turned off at that time. Review of the clinical record, however, revealed there was no physician order identifying the gastric residual amount at which nursing staff were to hold the tube feeding or notify the physician. Employee 13 further stated tube feeding intake amounts were not calculated or totaled and staff documented tube feeding administration on the MAR with a check mark only. She stated nursing staff were expected to document in a nurse's note when the tube feeding pump was turned off and restarted; however, she was unsure whether total daily tube feeding intake amounts were required to be documented. A review of a nutrition weight change note dated March 24, 2026, at 1:32 PM, revealed the resident weighed 99 pounds and remained dependent on tube feeding for 100 percent of nutritional needs. This weight noted a significant weight gain in the past 30 days. A review of a nutrition weight change note dated April 15, 2026, at 12:54 PM, revealed the resident weighed 98 pounds and remained dependent on tube feeding for nutritional support. A review of a nutrition weight change note dated May 6, 2026, at 12:06 PM, revealed the resident weighed 90.6 pounds and had triggered for significant weight loss over 30 days. The note stated the resident's current tube feeding was appropriate and no changes were recommended at that time. Review of the clinical record revealed the resident's significant weight loss occurred on April 19, 2026. There was no documented evidence that the Registered Dietitian addressed the significant weight loss until May 6, 2026. There was no documented evidence the Registered Dietitian reviewed or analyzed actual tube feeding intake amounts to determine whether the resident received ordered caloric and nutritional requirements. The Registered Dietitian employed during the period of weight loss was no longer employed by the facility at the time of the survey and was unavailable for interview.During a telephone interview on May 8, 2026, at 8:36 AM, the Corporate Registered Dietitian stated she was unaware of the resident's tube feeding concerns and significant weight loss and could not comment on issues of which she had no prior knowledge.During an interview on May 7, 2026, at 11:30 AM, the Director of Nursing (DON) confirmed the resident experienced significant weight loss while receiving enteral nutrition. The DON confirmed nursing staff did not calculate or total tube feeding intake amounts to determine whether residents receiving enteral nutrition met nutritional and caloric needs. The DON was unable to provide documented evidence that the facility effectively monitored, evaluated, and managed Resident 10's nutritional status and enteral feeding intake following the significant weight loss.Cross refer F80128 Pa. Code 211.12 (d)(1)(5) Nursing services. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of psychiatric consultation documentation, resident and staff interviews, and review of facility interventions, it was determined the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for one of 22 residents reviewed (Resident 28).Findings include: Review of Resident 28's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (a mental health disorder characterized by episodes of depression and periods of elevated mood, irritability, agitation, or depression). During an interview with Resident 28 on May 6, 2026, at 12:30 PM, the resident asked the surveyor if she worked for the eye doctor because he had been waiting for his glasses for a long time. The resident stated he could not see well without glasses and currently had none. The resident appeared visibly upset while discussing the lack of glasses. Review of outside psychiatric consultation documentation dated February 27, 2026, through May 1, 2026, revealed the resident's depression and emotional well-being were negatively impacted by not having glasses. Review of the psychiatric consultation dated February 27, 2026, revealed Resident 28 expressed concern regarding waiting for glasses. Documentation revealed the consultant social worker discussed the concern with the Director of Nursing (DON), who stated she had no knowledge regarding the resident's glasses. Review of the psychiatric consultation dated March 27, 2026, revealed the resident continued to express concern regarding not having glasses. Review of the psychiatric consultation dated May 1, 2026, revealed the resident remained concerned regarding the lack of glasses and demonstrated increased depression and irritability. The psychiatric assessment advised the facility to continue assessing for unmet needs contributing to emotional or behavioral disturbances, including hunger, thirst, comfort, and reassurance. Review of Resident 28's clinical record revealed documented behaviors including anxiety, attempting to self-rise, yelling out, cursing at staff, combative behaviors with attempts to hit staff, physical aggression toward peers, removing alarms, and throwing drinks and coffee. Review of Resident 28's behavior-related care plan revealed a focus area regarding these behaviors initiated by the facility on July 4, 2023. Further review revealed the care plan had not been revised since June 14, 2024, despite ongoing behaviors, increased depression, repeated psychiatric recommendations, and escalating behavioral episodes. Review of Resident 28's behavioral monitoring documentation revealed one intervention for the resident's behaviors included offering snacks. Review of a nursing progress note dated May 6, 2026, at 1:17 AM, revealed Resident 28 experienced a significant behavioral outburst. Documentation indicated the resident was yelling, screaming, and becoming aggressive toward staff. Staff were unable to de-escalate the resident and police were called to assist with de-escalation. Review of a nursing progress note dated May 6, 2026, at 3:10 AM, revealed writer was called to resident's room after resident was observed lying in bed yelling and using profane language toward staff. Upon approach, writer attempted to speak with resident; however, resident became verbally aggressive, stating that he needed food. Writer explained that staff had already provided all available food at that time. During an interview with the DON on May 7, 2026, at 11:00 AM, she was unable to explain why staff did not attempt to provide additional snacks or implement other individualized interventions to address the resident's unmet needs and de-escalate the resident's behaviors despite behavioral monitoring documentation identifying snacks as an intervention. During an interview with the Nursing Home Administrator (NHA) and DON on May 7, 2026, at 10:00 AM, they were unable to provide evidence the facility implemented effective individualized behavioral health interventions or provided the necessary behavioral health services to maintain or improve Resident 28's mental and psychosocial well-being. The facility failed to implement individualized behavioral health interventions and failed to provide effective non-pharmacological<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | approaches to address Resident 28's ongoing emotional distress, unmet needs, depression, irritability, and escalating behavioral symptoms. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Centers for Disease Control and Prevention (CDC) guidance, facility policy, clinical records, observations, and staff interviews, it was determined the facility failed to implement Enhanced Barrier Precautions (EBP) to prevent the potential spread of infection for two of 22 residents reviewed (Residents 9 and 34).Findings include: A review of the facility policy titled 'Enhanced Barrier Precautions', last reviewed March 26, 2026, revealed the policy was established to implement enhanced barrier precautions (EBP) for preventing the transmission of multi-drug resistant organisms. According to the policy, EBP refers to the use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with a Multi-Drug Resistant Organism (MDROs, germs that are resistant to multiple antibiotics and are more difficult to treat), as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The procedure stated that an order for EBP will be obtained for residents with wounds or residents with indwelling medical devices such as urinary catheters. EBP implementation includes having gowns and gloves immediately available outside the resident room, accessible alcohol-based hand rub, and a disposable container inside the room near the exit for discarding personal protective equipment (PPE, equipment such as gowns and gloves worn to reduce the spread of infection). High risk contact activities include dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care, and wound care. A review of CDC guidance for Enhanced Barrier Precautions revealed residents with wounds or indwelling medical devices are at increased risk for colonization and transmission of MDROs and should have Enhanced Barrier Precautions implemented during high-contact resident care activities. A review of Resident 34's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including obstructive sleep apnea (a disorder in which breathing repeatedly stops and starts during sleep). A review of Resident 34's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 11, 2026, revealed the resident was moderately cognitively impaired with a Brief Interview for Mental Status score of 9 (BIMS, a screening tool used to evaluate memory and thinking abilities) score of 08-12 indicates moderate cognitive impairment), indicating the resident had noticeable problems with memory and thinking. A review of a clinical record document titled Encore Wound Care dated May 5, 2026, revealed Resident 34 had a Stage 3 pressure ulcer on the sacrum (a deep wound located on the lower back near the tailbone involving loss of skin tissue through multiple skin layers). The wound was described as full-thickness tissue loss and measured 1.5 centimeters in length, 1 centimeter in width, and 0.2 centimeters in depth. Additional clinical record review of the care plan-initiated February 26, 2026, addressing Stage 3, pressure injury on the sacrum for Resident 34 included interventions for Enhanced Barrier Precautions. Review of physician orders revealed an order dated March 2, 2026, for EBP. During an observation conducted on May 5, 2026, at 2:25 PM, Resident 34's room did not contain evidence of EBP supplies, including gowns and gloves for high-contact resident care activities identified in the facility policy. During the observation, Employee 11, Licensed Practical Nurse (LPN), confirmed gowns and gloves were not available in the resident care area for Resident 34. A review of Resident 9's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the legs and feet). A review of Resident 9's quarterly MDS dated [DATE], revealed the resident was cognitively intact with a BIMS score of 15, indicating memory and thinking abilities were intact. A review of a clinical document titled Wound Care and Hyperbaric (High Pressure) Medicine /Active Wounds dated May 5, 2026, revealed Resident 9 had diabetic wounds on the left plantar and left lateral foot (open sores on the bottom and outer side of the foot caused by diabetes) and venous ulcers on the right distal pretibial and right proximal pretibial areas (open sores (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on the lower front portion of the leg caused by poor blood circulation). Review of Resident 9's physician orders and care plan failed to show evidence that Enhanced Barrier Precautions had been implemented despite the presence of multiple wounds identified in the clinical record. An interview with the Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA) on My 5, 2026 confirmed the facility did not follow its EBP policy for Residents 34 and 9. 28 Pa Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and facility documentation review, it was determined the facility failed to maintain a safe, comfortable, and functional environment by failing to ensure four Packaged Terminal Air Conditioner (PTAC) units were operational within resident care areas of the facility, including one resident out of 22 reviewed (Resident 39). Findings include During an interview with Resident 39, on May 5, 2026, at 12:00 PM, she stated that the PTAC unit (a self-contained heating and cooling unit used to regulate room temperature and resident comfort) in her room was not functioning. Resident 39 stated her roommate preferred the air conditioning because she became hot; however, the unit had not been working. When asked how long the unit had been nonfunctioning, Resident 39 stated it had been a long time, months at least. During an interview on May 5, 2026, at 2:00 PM, the Director of Maintenance stated the facility had four nonfunctioning PTAC units within the building. The Director of Maintenance identified the affected locations as the Physical Therapy Department, room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. The Director of Maintenance stated replacement units had been ordered; however, he was unable to provide documentation or evidence confirming the units or repair parts had actually been ordered. Documentation provided by the facility included pricing estimates dated April 30, 2026, for replacement units and repair parts. The documentation did not include purchase orders, invoices, shipping confirmations, or other evidence demonstrating the units or parts had been ordered. On May 6, 2026, surveyors requested additional documentation confirming the replacement units or repair parts had been ordered. The facility provided another estimate dated May 5, 2026. No documentation was provided confirming the units or parts had been purchased or ordered. During an interview on May 6, 2026, at 1:00 PM, the Nursing Home Administrator was unable to provide evidence that the facility had taken timely action to repair or replace the nonfunctioning PTAC units to ensure residents were provided with a comfortable environment. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. |