STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395279	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinecrest Manor	763 Johnsonburg Rd St Marys, PA 15857

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of five of 24 residents reviewed (Residents R94, R30, R105, R70, and R42).Findings include: MDS instructions for section J Health Conditions, Subsection J1800 Any Falls Since Admission/Entry or Reentry or Prior Assessment indicated Has the resident had any falls since admission/entry or reentry or the prior assessment whichever is more recent? MDS instructions for section K0300 indicated that if weight loss of five percent or more in the last month or loss of 10 percent or more in the last six months to code yes. The MDS instructions further indicated to calculate 10 % weight loss in 180 days, start with the resident's weight closest to 180 days ago. MDS instructions for section PO200 revealed to identify all alarms that were used at any time (day or night) during the seven-day look-back period and to code the frequency of use as not used, used less than daily or used daily. The MDS instructions further indicated that a bed alarm includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing. The MDS instructions further indicated that a chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing. MDS instructions for section N Medications, subsection N0350A Insulin Injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. MDS instructions for section N Medications, subsection N0350B Orders for Insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days. MDS instructions for section N Medications, subsection N0415E1 High-Risk Drug Classes: Use and Indication Anticoagulant - check if the resident is taking any medications by pharmacological classifications, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Resident R94's clinical record revealed an admission date of 11/08/25, with diagnoses that included displaced intertrochanteric fracture of the femur (fractured hip), high blood pressure, and history of falling. Resident R94's discharge MDS with an Assessment Reference Date (ARD- a look back period of time for the MDS assessment) of 12/19/25, revealed section J1800 Has the resident had any falls since admission/entry or reentry or the prior assessment, whichever is more recent? was coded as 0. No Resident R94's clinical record progress note dated 12/19/25, revealed that Resident R94 was found on floor and complaining of left hip and groin pain, orders obtained to send resident to ER for evaluation. Progress note dated 12/20/25, revealed Resident R94 was admitted with fractured femur under the hardware from previous fracture. During an interview on 1/29/26, at 1:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that Resident R94's 12/19/25, MDS was coded inaccurately regarding falls. Resident R30's clinical record revealed an admission date of 7/16/15, with diagnoses that included cerebral palsy (congenital disorder of movement/muscle tone/posture), anorexia nervosa (an eating disorder in which people have a low body weight based on personal weight history), and depression (characterized by persistent feeling of sadness loss of interest in (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities once enjoyed). Review of Resident R30's clinical record revealed evidence of weight loss in the last six months. On 4/02/25, Resident R30 weighed 76.1 pounds (lbs). On 9/01/25, he/she weighed 62.4 lbs which is a -18% Loss. On 3/10/25, Resident R30 weighed 73.9 lbs. On 9/01/25, he/she weighed 62.4 lbs which is a -15.56% Loss. On 2/05/25, Resident R30 weighed 77.8 lbs. On 9/01/25, he/she weighed 62.4 lbs which is a -19.79% Loss. Resident R30's quarterly MDS with an ARD of 9/1/25, under section K-Swallowing/Nutritional Status section K0300 Weight loss revealed for loss of 5% in the last month or loss of 10% or more in last 6 months was coded as No or unknown. During an interview on 1/29/26, at 2:15 p.m. Registered Dietitian Employee E2 confirmed that Resident R30 did have significant weight loss and the MDS dated [DATE], for Section K-Swallowing/Nutritional Status Section K0300 Weight Loss was coded incorrectly and should have been coded as yes, not on prescribed weight-loss regimen. Resident R105's clinical record revealed an admission date of 12/02/25, with diagnoses that included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), high blood pressure and repeated falls. Resident R105's clinical record revealed a physician's order dated 12/2/25, for Chair/bed pull alarm-check function and placement every shift for fall/safety intervention. An admission MDS with an ARD of 12/9/25 revealed that section P0200A bed alarms, and P0200B chair alarms was coded as not used. Observations between 1/27/26 and 1/29/26, revealed Resident R105 had a chair alarm attached while sitting in his/her wheelchair. Resident R105's clinical record revealed a completed Treatment Administration Record (TAR) for chair/bed pull alarm-check function and placement every shift since ordered on 12/2/25. During an interview on 1/30/26, at 9:05 a.m. RNAC Employee E1 confirmed Resident R105's MDS was coded inaccurately for section P0200A bed alarms, and P0200B chair alarms and should have been coded as Used Daily. Resident R70's clinical record revealed an admission date of 3/18/24, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and high blood pressure. Resident R70's quarterly MDS with an ARD of 6/6/25, revealed section N0350B Orders for Insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days. was coded 1. Resident R70's quarterly MDS's with an ARD of 9/2/25, and 12/3/25, revealed section N0350A Insulin Injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. was coded as 1. Review of R70's physician orders from 3/18/24, through 1/30/25, lacked evidence of Resident R70's being ordered or receiving insulin. During an interview on 1/30/26, at 9:07 a.m. RNAC Employee E1 confirmed that Resident R70 was never ordered and did not receive insulin and quarterly MDS's with ARD of 6/6/25, 9/29/25, and 12/3/25, were coded inaccurately regarding receiving insulin and changes in insulin orders. Resident R42's clinical record revealed an admission date of 1/9/19, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), Parkinson's Disease (a movement disorder of the nervous system that may result in tremors, stiffness, slowing of movement, and trouble with balance that worsens over time), and COPD. Resident R42's quarterly MDS with an ARD of 9/8/25, revealed section N0415E Anticoagulant - check if the resident is taking any medications by pharmacological classifications, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. was coded as No. Resident R42's physician orders revealed an order dated 8/5/25, for Apixaban (Eliquis - an anticoagulant medication used to reduce risk of stroke and blood clots in adults with A-Fib) 5 milligrams (mg) twice a day. Medication Administration Record (MAR) for September 2025, revealed Resident R42 received Apixaban twice a day during the entire 7-day lookback period. During an interview on 1/30/26, at 9:08 a.m. RNAC Employee E1 confirmed that Resident R42 received an anticoagulant medication during the entire 7-day lookback period and his/her 9/8/25, was coded inaccurately regarding use of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticoagulant medication. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical records

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 24 residents reviewed (Resident R7).Findings include: Review of facility policy dated 11/18/25, entitled Care Plans: Interdisciplinary indicated the purpose is to provide a comprehensive care plan that includes measurable objectives and timetables to meet medical, nursing, mental, and psychosocial needs that are identified including those identified in the comprehensive assessment. The policy further stated that care plans will be reviewed quarterly and for significant changes and hospital returns as well as staff updating as required between care plan conferences. Resident R7's clinical record revealed an admission date of 5/29/29, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and Schizoaffective Disorder)a mental health condition that can be a mix of symptoms such as hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and depression [persistent feeling of sadness loss of interest in activities once enjoyed]). Resident R7's clinical record revealed a physician's order dated 10/25/25, for Novolog (medication used to treat diabetes) 12 units subcutaneously (sq - a short needle is used to inject a drug into the tissue layer between the skin and the muscle) every morning with breakfast, 12 units sq every afternoon with lunch, 10 units sq every evening, and coverage according to sliding scale with meals and at bedtime. Resident R7's clinical record further revealed an annual Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care) with an Assessment Reference Date of (ARD - a look back period of time for the MDS assessment) of 10/30/25, indicating Resident R7 received insulin injections during the look-back period. Resident R7's clinical record lacked evidence that a care plan had been developed to address his/her usage of insulin. During an interview on 1/30/25, at 9:09 a.m. Registered Nurse Assessment Coordinator Employee E1 confirmed that a care plan had not been developed to address Resident R7's use of insulin. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy and drug manufacturer instructions, observation, and staff interview, it was determined that the facility failed to appropriately date and store medications in one of four medication carts reviewed (C Hall Medication Cart). Findings include: Review of facility policy dated 11/18/25, entitled Pharmaceutical Services and Medication Storage revealed the facility must adhere to all relevant state, federal, and local regulations, included those from the Department of Health, Food and Drug Administration, and Drug Enforcement Agency and State Boards of Pharmacy regarding the storage, handling, and administration of all medications. Manufacturer's guidelines for Trelegy Ellipta (medication used to treat Chronic Obstructive Pulmonary Disease [COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing] and Asthma [a long-term inflammatory disease of the airways that cause the airways to narrow and swell causing symptoms such as wheezing, coughing, chest tightness, and shortness of breath], indicated that Trelegy should be discarded six weeks after opening the foil tray or when the counter read 0, whichever comes first. Manufacturer's guidelines for Fluticasone Salmeterol also known as Advair Diskus (maintenance medication used to prevent flare-ups or worsening COPD and prevent asthma attacks), indicated that Fluticasone Salmeterol should be safely thrown away in the trash one month after the foil pouch is opened or when the counter reads 0, whichever comes first. Observation on 1/27/26, at 1:19 p.m. of C-Hall Medication Cart, revealed one Trelegy Ellipta Diskus with the foil container opened, diskus in use, and diskus lacking an open date and one Fluticasone Salmeterol Diskus out of the foil package, diskus in use, and diskus lacking an open date. At the time of observation, Licensed Practical Nurse Employee E3 confirmed the Trelegy Ellipta and Fluticasone Salmeterol were both opened, in use and lacked an open date. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services