STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395288	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Care and Rehab Center	221 East Brown Street East Stroudsburg, PA 18301

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy review, and staff interview, it was determined the facility failed to ensure a resident was free from a chemical restraint and failed to ensure non-pharmacological interventions were attempted and documented prior to administration of a psychotropic medication for one of 10 residents reviewed (Resident CR1). Findings include: A review of the facility policy titled Use of Psychotropic Medication, last reviewed by the facility on February 24, 2026, revealed it is the facility policy to ensure residents do not receive psychotropic medication (medications that affect the chemical makeup of the brain and nervous system, altering mood, cognition, and perception) that are not clinically indicated and necessary to treat a specific condition documented in the medical record. The policy also indicated that behavioral and other non-pharmacological approaches (non-medication approaches used to manage symptoms or behaviors, such as environmental, behavioral, or comfort measures) are used to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. The policy indicated psychotropic medication may be considered appropriate when non-pharmacological approaches have been attempted and documented as ineffective in relieving symptoms causing significant distress or presenting safety concerns. The clinical record review revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a progressive, fatal neurological disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes due to brain cell death) and dementia (a progressive syndrome caused by abnormal brain changes that damage cells and impair memory, thinking, behavior, and daily functioning). A review of Resident CR1's Medicare 5 day Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 20, 2026, revealed that Resident CR1 was moderately cognitively impaired with a BIMS score of 08 (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 08 to 12 indicates moderate cognitive impairment). Review of the comprehensive care plan revealed a focus area identifying Resident CR1 as being at high risk for elopement (leaving the facility unsafely or without staff knowledge) related to exit-seeking behaviors. Interventions included reorientation to surroundings, frequent monitoring of the resident's location, encouraging participation in structured activities, providing diversion activities, redirecting the resident away from exits, and providing the resident with diversional activities to reduce exit seeking behaviors. A review of physician orders revealed Resident CR1 prescribed the following medications on the resident's date of admission March 14, 2026: Divalproex 125mg capsules (a medication affecting brain chemistry sometimes used off label to manage behavioral symptoms associated with dementia). Ordered dose: 250 mg by mouth every morning and at bedtime related to dementia with other behavioral disturbance. Donepezil 10mg tablets (a medication used to treat symptoms of dementia by supporting cognitive function). Ordered dose: one tablet by mouth at bedtime. Memantine 10mg tablets (a medication used to treat moderate to severe (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia by regulating brain signaling). Ordered dose: one tablet by mouth every 12 hours. A review of CR1's progress notes revealed a physician progress note dated March 16, 2026, at 1:40 PM indicating resident CR1 was adjusting well since admission with no acute issues identified. Review of physician orders dated March 16, 2026, at 12:15 PM revealed an order for Quetiapine Fumarate 25 mg tablets (an antipsychotic medication used to affect mood and behavior), to be administered every 12 hours as needed (PRN, administered when symptoms occur rather than on a routine schedule) for agitation. Review of the March 2026 Medication Administration Record (MAR) revealed Resident CR1 received PRN quetiapine on March 16, 2026, at 8:09 PM. The clinical record failed to document symptoms of agitation requiring medication use and did not include documentation of non-pharmacological interventions attempted prior to administration. Progress notes revealed the following:On March 17, 2026, at 2:48 PM, Resident CR1 was documented attempting to open the facility front door. Family was contacted, and the resident was moved to another unit in an attempt to reduce elopement risk. On March 18, 2026, at 6:51 AM, Resident CR1 was documented as awake all night with agitation and exit-seeking behaviors. Documentation indicated redirection (guiding the resident away from exits or concerning behavior using verbal reassurance or engagement) was effective. On March 19, 2026, at 1:19 PM, Resident CR1 was documented attempting to open a dining room window and expressing a desire to go home with her husband. Documentation indicated staff contacted the resident's husband, after speaking with her husband, the resident became calmer and consumed lunch. On March 20, 2026, at 2:03 PM, Resident CR1 was administered PRN quetiapine after documentation indicated the resident was upset, refusing lunch, searching for her husband, and attempting to pull the fire alarm. Documentation indicated redirection was not effective prior to administration. On March 20, 2026, at 2:54 PM, follow-up documentation indicated the resident was resting quietly in her wheelchair and appeared calm and relaxed. On March 22, 2026, at 8:54 PM, documentation indicated Resident CR1 slept most of the shift, did not eat dinner, and was difficult to arouse. When the nurse aide attempted to wake the resident, CR1 would open 1 eye and roll over back to sleep. The note indicated the resident had been awake most of the previous night and crashed during the day. The note documented the resident's dinner tray would be held for later. On March 23, 2026, at 10:38 AM, Resident CR1 received PRN quetiapine for anxiety and agitation related to searching for her husband and attempting to leave the unit to find him. Documentation did not include evidence of non-pharmacological interventions attempted prior to administration. A physician progress note on March 23, 2026, at 7:25 PM documented CR1 was evaluated for dementia. The note documented that resident CR1 was recently agitated and searching for her husband. The note indicated the resident was exhibiting restlessness and confusion, but no aggressive behaviors were reported. The note documented the resident remained redirectable with staff support. The note documented physician recommendations to continue non-pharmacological interventions such as reorientation, reassurance, structured routine, and to provide a calm environment for CR1 and provide redirection as needed. The note documented to monitor resident CR1 for escalation of agitation or safety concerns and to notify the provider immediately of any increase or change in behavior. A progress note on March 24, 2026, at 10:02AM documented that Resident CR1 received PRN quetiapine; however, the clinical record did not document behaviors requiring medication, non-pharmacological interventions attempted, or clinical justification for administration. Review of the clinical record failed to demonstrate the facility defined Resident CR1's behavioral expressions of anxiety, agitation, or aggression in observable and measurable terms to guide staff in determining when administration of quetiapine was clinically indicated. Without clearly defined parameters, staff lacked objective criteria to support consistent and appropriate decision-making regarding PRN psychotropic medication used to ensure the medication was administered appropriately and consistently. Review of Resident CR1's clinical record revealed no documented evidence non-pharmacological interventions were attempted and found ineffective prior to administration of quetiapine for two of four administrations reviewed. During an interview conducted April 15, 2026, at 11:50 AM, the above findings were reviewed with the Director of Nursing. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing was unable to provide documented evidence demonstrating non-pharmacological interventions were consistently attempted prior to administration of PRN quetiapine for 50 percent of administrations reviewed. The Director of Nursing was also unable to provide documentation demonstrating the facility defined Resident CR1's specific behavioral symptoms in measurable terms to guide staff in determining when administration of quetiapine was clinically indicated. During an interview conducted April 15, 2026, at 11:50 AM, the above findings were reviewed with the Director of Nursing. The facility did not provide documentation showing that non-pharmacological interventions were attempted prior to two of four administrations of PRN quetiapine and did not provide documentation identifying the specific behaviors indicating when use of the medication was appropriate. The clinical record did not demonstrate consistent implementation of individualized non-pharmacological interventions or sufficient documentation supporting the clinical need for each PRN administration of the antipsychotic medication. 28 Pa. Code 211.2(3) Medical director. 28 Pa. Code 211.5(ii)(xi) Clinical records. 28 Pa. Code 211.8(e) Use of restraints. 28 Pa. Code 211.9(1) Pharmacy services. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.