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	08/15/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, select facility policy, and resident and staff interviews, it was determined the facility failed to reasonably accommodate residents' need for call bell accommodation for one out of 29 residents sampled (Resident 18).Findings include: A review of a facility policy titled Call Light Policy, last reviewed by the facility on August 7, 2025, revealed that it is the policy to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Further review revealed that each resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system, and any special accommodations will be identified on the resident's person-centered plan of care and provided accordingly, with examples to include touch pads, larger buttons, and bright colors. A review of Resident 18's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include hemiplegia (paralysis on one side of the body) and muscle wasting and atrophy (thinning of muscle mass). A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 9, 2025, revealed that Resident 18 had moderately impaired cognition with a BIMS score of 12 (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 8-12 indicates cognition is moderately impaired). Further clinical record review of a skilled nursing progress note, dated July 17, 2025, revealed that Resident 18 was contracted in both upper and lower extremities. Contractures are a permanent shortening of muscles, tendons, or joints, often due to immobility or neurological conditions, which can cause stiffness and limit movement. Observations made during an interview with Resident 18 on August 13, 2025, at approximately 11:00 AM, revealed that the resident had contractures to both hands. During the interview, it was revealed that Resident 18 was unable to use his push-button call bell due to these contractures. Resident 18 stated that he had not been able to use his call bell for assistance at the facility and would like a touch-sensitive call bell system. An interview with Employee 1, Licensed Practical Nurse, conducted on August 13, 2025, at approximately 11:15 AM, confirmed the observation that Resident 18 was unable to utilize the standard push-button call light due to his hand contractures. Following surveyor inquiry, observation at approximately 12:00 PM on August 13, 2025, revealed that the facility did provide a touch-sensitive call light device, which Resident 18 was able to operate. During an interview with the Nursing Home Administrator on August 13, 2025, at approximately 12:30 PM, it was confirmed that Resident 18 had not been provided with a call system compatible with his physical needs prior to the surveyor's inquiry. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services. 28 Pa. Code 201.29 (a) Resident Rights.

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

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	08/15/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to demonstrate that a resident's discharge from the facility was appropriate and necessary, for one of three sampled residents (Resident 112). Findings include: Clinical record review revealed that Resident 112 was admitted to the facility on [DATE], with diagnoses to include acute kidney failure (an abrupt decrease in kidney function, resulting in the retention of waste products) and unsteadiness on feet. Review of an entry Minimum Data Set Assessment (MDS a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated July 7, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 14 indicating she was cognitively intact. A review of Resident 112's hospital discharge history and physical paperwork from July 7, 2025, revealed the resident had been hospitalized in part due to her inability to care for herself. Review of Resident 112's clinical record revealed the resident was discharged home from the facility on July 19, 2025. Information provided from the Area Agency on Aging revealed upon return home the resident had no food in her home that the only item in the refrigerator/freezer was ice cubes. A review of Resident 112's clinical record revealed social service notes dated July 18, 2025, indicating residents discharge planning had been discussed with the resident's family. However, there were no social service notes indicating how the family would assist the resident with acquiring food and other services to assist the resident in the transition to home, given the resident's prior difficulty in caring for herself. During an interview on August 14, 2025, at approximately 11:00 AM, the Director of Social Services (SS) confirmed Resident 112 was to be discharged to her home. The Director of SS was unable to provide documented evidence that Resident 112 would receive the required care and services to ensure a safe discharge to home. A physician discharge note dated July 19, 2025, indicated Resident 112 arrived at the facility after a hospitalization due to increased weakness and inability to care for herself, and was to be discharged home. The facility failed to demonstrate that the discharge was appropriate. During an interview with the Social Service Director on August 14, 2025, at 12:00 PM it was unable to provide documented evidence that Resident 112's discharge was safe and appropriate.28 Pa. Code 201.29(h) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the Resident Assessment Instrument, and staff interview, it was determined the facility failed to ensure that Minimum Data Set Assessments accurately reflected the status of two residents out of 29 sampled. (Residents 21 and 72).Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section K0300 Weight Loss the facility is to record loss of 5% or more in the last month or loss of 10% or more in the last 6 months. A clinical record review revealed Resident 21 was admitted to the facility on [DATE]. Resident 21 was transferred to the hospital on July 17, 2025, and readmitted to the facility on [DATE]. A review of a Medicare 5 day Minimum Data Set Assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 29, 2025, indicated in Section K0200 that the resident's height was 67 inches and weight was 107 pounds. Review of Section K0300 indicated that Resident 21 did not experience a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Review of Resident 21's Weight Record revealed that on June 13, 2025, the resident weighed 123 pounds. On July 29, 2025, the resident weighed 107 pounds which is indicative of a 13 % significant weight loss in the last month. During an interview on August 14, 2025, at approximately 11:00 AM the Registered Dietitian (RD) confirmed that Resident 21 did experience a 18.6% weight loss between June 13, 2025, and the Medicare 5 day MDS assessment dated [DATE], and that Section K0300 was inaccurate. According to the RAI User's Manual dated October 2024, Section O, Special Treatments, Procedures, and Programs O 0110 J1 Dialysis, indicates facilities will code peritoneal or renal dialysis, which occurs at the nursing home or at another facility, and record treatments of hemofiltration, slow continuous ultrafiltration (SCUF), continuous arteriovenous hemofiltration (CAVH), and continuous ambulatory peritoneal dialysis (CAPD) in this item. Intravenous (IV) medication and blood transfusions administered during dialysis are considered part of the dialysis procedure. A clinical record review revealed Resident 72 was admitted to the facility on [DATE], with diagnoses which included end-stage renal disease (final stage of chronic kidney disease in which the kidneys no longer support the body's needs) with maintenance hemodialysis (a machine filters wastes, salts, and fluid from the blood when the kidneys are no longer healthy enough to function) every Monday, Wednesday, and Friday. A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) Section O 0110. Special Treatments, Procedures, and Programs, J1, Dialysis completed for Resident 72, dated August 5, 2025, indicated the resident did not receive dialysis treatments while a resident at the facility. Further review of the clinical record revealed that Resident 72 did receive dialysis treatments on August 1 and August 4, 2025. During an interview on August 13, 2025, at approximately 1:00 PM, the Registered Nurse Assessment Coordinator (RNAC) confirmed that Resident 72's was receiving dialysis services. The RNAC confirmed the facility coded Resident 72's MDS assessment dated [DATE], in error as related to dialysis services. 28 Pa. Code 211.5(f)(i) Medical records. 28 Pa. Code 211.12(d)(3) Nursing services.

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	395288	A. Building B. Wing	08/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy, and staff interviews, it was determined the facility failed to provide professional standards of practice for diabetes management for one resident out of 29 sampled (Resident 119). Findings include: A review of facility policy entitled Administering Medications, last reviewed on August 7, 2025, revealed that medications must be administered in accordance with the physician's orders and if the dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concerns. A review of Resident 119's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin {a hormone that helps regulate blood sugar levels} or when the body cannot effectively use the insulin it produces). A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 22, 2025, revealed that Resident 119 had moderately impaired cognition with a BIMS score of 9 (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 8-12 indicates cognition is moderately impaired). A clinical record review for Resident 119 revealed physician orders, dated June 10, 2025, for insulin aspart 5 units subcutaneous (under the skin) injection four times a day. A review of Resident 119's Medication Administration Record (MAR) for July 2025 revealed the following:Insulin aspart was held on July 20, 2025, at 11:00 PM administration with a documented blood glucose of 94 mg/dL.Insulin aspart was held on July 29, 2025, at the 5:00 PM administration with a documented blood glucose of 103 mg/dL.Insulin aspart was held on July 29, 2025, at the 11:00 PM administration with a documented blood glucose of 118 mg/dL. Further review of Resident 119's MAR for August 2025 revealed the following:Insulin aspart was held on August 2, 2025, at the 5:00 PM administration with no blood glucose documented.Insulin aspart was held on August 2, 2025, at the 11:00 PM administration with a documented blood glucose of 101 mg/dL.Insulin aspart was held on August 7, 2025, at the 2:00 PM administration with a documented blood glucose of 99 mg/dL. A review of Resident 119's clinical record revealed no physician orders indicating parameters for holding insulin aspart. Additionally, there was no documented evidence that the physician was notified that insulin doses had been withheld on the above dates. During an interview with the Nursing Home Administrator on August 15, 2025, at approximately 10:30 AM, the aforementioned information regarding the administration of the insulin aspart was reviewed. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.10 (c)(d) Resident care policies.

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	08/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, resident observation, and staff interview, it was determined the facility failed thoroughly assess and timely implement treatments to an identified skin impairment for one resident out of 29 sampled residents (Resident 16). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility's policy titled Prevention of Pressure Ulcers/Injuries last reviewed August 7, 2025, indicated staff will inspect the skin on a daily basis and identify any signs of developing pressure injuries, inspect pressure points such as sacrum (lower back at the base of the spine), heels, buttocks, coccyx (tailbone), elbows, ischium (lower pelvic bones), and trochanter (hip area). According to the policy, staff will evaluate, report, and document potential changes in the skin and review interventions and strategies for effectiveness on an ongoing basis. The policy further states that weekly body audits will be performed, and a resident-centered care plan will be based upon the risk factors identified in the assessment. A review of Resident 16's clinical record revealed Resident 16 was admitted to the facility on [DATE], with diagnoses which included but not limited to Alzheimer's disease, unspecified (a condition that slowly affects how a person thinks, remembers, and acts) and muscle wasting and atrophy (muscles become smaller and weaker over time). A review of the March 28, 2025, Minimum Data Set (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) identified Resident 16 required partial/ moderate assistance (helper does less than half the effort) with aspects of mobility including roll left to side, sitting to lying, sit to stand, chair/bed to chair transfer, and toilet transfer. Review of the June 20, 2025, MDS noted Resident 16 required substantial/ maximal assistance (helper does more than half the effort) with aspects of mobility including roll left to side, sitting to lying, sit to stand, chair/bed to chair transfer, and toilet transfer. The June 20, 2025, MDS illustrated an increase in assistance and decrease in mobility experienced by Resident 16. Clinical record review of Resident 16's plan of care that was initiated on February 11, 2024, identified Resident 16 was at risk for pressure ulcer development related to cognitive deficits and incontinence of bladder and bowel. Among the stated goals included the absence of skin injury including redness, blisters or discoloration by/through review date. Planned interventions included administer treatments as ordered and observe for effectiveness as well as informing MD, responsible party, resident and caregivers of any new area of skin breakdown. A nurse practitioner progress note dated July 1, 2025, documented a Stage II pressure injury (skin is broken, it's deeper than red skin but has not gone into the muscle or bone), on the sacral (lower back, base of spine, tailbone location) area measuring 0.8cm (length) x 0.8cm (width) x 0.1cm (depth), with exposed dermis (middle layer of skin), no odor, peri wound (skin surrounding wound) was intact, wound base 100% epithelial (covering that lines the skin), light amount of serous exudate (thin, watery drainage), wound edges were attached, and no pain was evaluated at the time. A treatment was initiated to cleanse with normal saline, apply Silvasorb gel (a wound dressing with antimicrobial properties) to the base of the wound, covering with a bordered dressing to be changed daily and as needed. Clinical record review of Resident 16's 'Preventative skin care observation' forms for the month of July 2025 and August, 2025 illustrate no new concerns. A review of the Treatment Administration Record (TAR) for July 2025 documented wound treatments were carried out on most days but revealed omissions on July 8, July 9, July 26, August 1, and August 2, 2025. The clinical record lacked documentation of wound monitoring or weekly measurements after July 1, 2025. Progress notes by the nurse practitioner from July 8, 2025, documented refusal of evaluation by the resident but incorrectly indicated the wound was resolved based only on staff report. Further nurse practitioner notes between July 11 and July 25, 2025

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	08/15/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, physician orders, resident interview, and staff interview, it was determined the facility failed to provide restorative nursing services and a therapeutic device prescribed to maintain mobility and current level of functioning as ordered by the physician and recommended by rehabilitative therapy staff for one resident (Resident 4) out of five sampled residents. Findings include: Review of the facility Restorative Nursing Services Policy last updated August 7, 2025, indicated that residents will receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of stay, or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. The resident or resident representative will be included in determining goals and the plan of care. A review of Resident 4's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side. A physical therapy Discharge summary dated [DATE], recommended a restorative nursing program (RNP) consisting of bilateral lower extremity (BLE) assisted active range of motion (AAROM) exercises, 10 repetitions times two sets for 15 minutes daily. AAROM is an exercise in which the resident moves a body part through its range of motion with the assistance of another person. A physician order dated April 24, 2025, confirmed this recommendation. An occupational therapy Discharge summary dated [DATE], recommended a restorative nursing program to include active range of motion (AROM resident moves joints independently without assistance) to the left upper extremity each joint 10 repetitions times one set. The summary also recommended a splint and brace program, including inspection of skin integrity, application of a left modified palm guard (a therapeutic device applied to the hand for individuals with limited hand function) during evening care and removal in the morning, and positioning the left upper extremity in an elevated and supported position while in bed. Physician orders dated June 20, 2025, confirmed both the AROM and the splint/brace interventions. A review of Resident 4's current plan of care identified a focus area of self-care deficit related to stroke, with a goal to improve the current level of function. However, the plan of care failed to identify or incorporate the resident's restorative nursing needs as ordered. Interview with Resident 4 on August 15, 2025, at 12:10 PM revealed that he did not recall receiving any restorative exercises since being discharged from therapy. Resident 4 also noted that staff have not consistently been applying the palm guard to his left hand. Further review of the clinical record failed to provide any documented evidence that the resident's restorative nursing was offered to the resident by staff as ordered by the physician. There was no documented evidence that the resident's modified palm guard was being applied as ordered by the physician to the resident's left hand. Interview with the Nursing Home Administrator on August 15, 2025, at approximately 11:30 AM failed to provide documented evidence that the resident's restorative nursing program which included exercises and a modified palm guard to the left hand to maintain the resident's mobility to the extent possible were being provided as ordered by the physician. 28 Pa. Code: 211.5(f)(i)(ii) Medical records. 28 Pa Code 211.1 (d) Resident care policies. 28 Pa Code 211.12 (c)(d)(5) Nursing services.

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	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and staff interviews, it was determined that the facility failed to demonstrate an effective maintenance program of inspection of all bed frames with bed extenders to assure the limiting of entrapment zones and promote resident safety for two residents out of 29 sampled (Resident 1 and Resident 7) and in three resident rooms observed.Findings included: Entrapment is a situation in which a resident's head, neck, chest, or limbs can become trapped between parts of a hospital bed system such as the mattress, bed frame, side rails, or footboard. The U.S. Food and Drug Administration (FDA) and the Centers for Medicare & Medicaid Services (CMS) according to Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued March 10, 20026 identify seven potential entrapment zones, including the space between the mattress and the footboard of the bed (Zone 6). Zone 7 Between the Head or Foot Board and the End of the Mattress When there is too large of a space between the inside surface of the headboard or footboard and the end of the mattress, the risk of head entrapment increases. Such gaps can result in serious injury or death if a resident becomes caught in them. Facilities are expected to inspect and maintain bed systems to minimize or eliminate entrapment hazards. Observations made during an interview with Resident 7 on August 13, 2025, at approximately 9:00 A.M., revealed a bed frame with a bed extender being utilized due to the resident's height that had an approximately 4 inches to 6 inch gap from the bottom of the mattress to the footboard of the bed. Observations made of Resident 1 on August 13, 2025, at approximately 9:30 A.M., revealed a bed frame with a bed extender that had a gap from the bottom of the mattress to the footboard that was filled in with wedges that are normally used for repositioning. Observations made during a tour of the facility of the second floor on August 13, 2025, at approximately 9:35 A.M., revealed a bed frame with a bed extender that had a gap from the bottom of the mattress to the footboard in rooms 205-B and 210-B. An interview on August 15, 2025, at approximately 10:00 A.M., with the physical therapy director, revealed that when a bed extender is used, it was the facility's practice to place a wedge in the gap created by the extender. The director acknowledged that wedges commonly used for repositioning were being applied in these circumstances. The information regarding bed extenders and maintenance of bed gaps was reviewed with the Nursing Home Administrator on August 15, 2025, at approximately 10:15 A.M. 28 Pa. Code 201.18 (e) (2. 1) Management.

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	08/15/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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	395288	A. Building B. Wing	08/15/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and staff interviews, it was determined that the facility failed to follow its own policies and procedures for monitoring nutritional status, obtaining weights, completing reweights, and ensuring timely notification of significant weight changes for six of ten sampled residents (Residents 16, 18, 21, 97, 107, and 119). Findings include: A review of the facility's Nutritional Assessment Policy last reviewed August 7, 2025, indicated that as part of the comprehensive assessment, a nutritional assessment, including nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by change in condition that place the resident at risk for impaired nutrition. The nutritional assessment will be conducted by the interdisciplinary team and identify components which include Nursing: current height and weight, a description of the resident's usual intake and appetite, a history of reduced appetite or progressive weight loss or gain prior to admission, a description of the resident's overall appearance, Physician: current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors, current laboratory results related to fluid and electrolyte status, and the presence of chewing or swallowing abnormalities, and Dietitian: an estimate of calorie, protein, and fluid needs, whether the resident's current intake is adequate to meet his or her nutritional needs, and special food formulations. A review of the facility Weight Policy last reviewed August 7, 2025, indicated the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for residents. Nursing staff will measure resident weights on admission and the next day, weekly for four weeks then monthly thereafter. Obtain weights as needed based on acuity. Weights will be recorded in the resident's medical record. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian. The dietitian will review individual weight trends over time. Negative trends will be evaluated by the treatment team whether the criteria for significant weight change have been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month 5% weight loss is significant; 3 months 7.5% weight loss is significant; 6 months 10% weight loss is significant. Clinical record review noted Resident 16 was admitted to the facility on [DATE], with diagnoses which included but not limited to Alzheimer's disease, unspecified (a condition that slowly affects how a person thinks, remembers, and acts), Muscle wasting and atrophy (muscles become smaller and weaker over time). Clinical record review of the nutrition notes dated March 11, 2025, reported a weight of 113 lbs. and confirmed Resident 16 experienced a significant loss of 9.0 lbs. (7.4%) in 30 days, significant loss of 12. 0 lbs. (9.6%) in 90 days, and a non-significant loss of 5.0 lbs. (4.2%) in 180 days. Ensure (commercially prepared nutritional beverage) was then recommended on March 11, 2025, to address the weight loss. There was no documented evidence that Resident 16's resident representative and provider was notified. Further review of the nutrition note, dated April 25, 2025, documented the resident's weight as 109 pounds and confirmed that the resident continued to experience weight loss of 6.2% in approximately 50 days and 7. 5% in 90 days. There was no documented evidence in the clinical record that further nutritional interventions were initiated at that time, or that the resident's physician or resident representative was notified of the changes. A progress note dated May 9, 2025, documented a change in nutritional supplements, discontinuing Ensure (a commercially prepared nutritional beverage) and substituting double desserts, citing the resident's lack of tolerance and acceptance of Ensure. The clinical record contained no documented evidence that the resident's weight trend or response to this intervention was evaluated in accordance with facility policy. Review of the nutrition note, dated June 20, 2025, documented the resident's weight at 108.2 pounds and showed a cumulative weight loss of 16.8 pounds (13.4%) in 180 days. There was no documented evidence that the resident's physician or representative was notified of this significant weight loss, nor was there evidence that the required reweight was obtained to confirm accuracy or prompt reassessment of nutritional interventions. Clinical record review revealed that Resident 18 was admitted to the facility on [DATE], with diagnoses to include hemiplegia (paralysis on one side of the body) and muscle wasting and atrophy (thinning of muscle mass) and was dependent on tube feedings for nutrition. The resident was weighed on admission and the following day; however, no weekly weights were obtained for the next four weeks as required by facility policy. Records showed that the last documented weight was July 4

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	08/15/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of controlled drug shift count records, select facility policy, observations of the medication cart, and staff interviews, it was determined that the facility failed to implement procedures to promote accurate documentation of controlled medications for one of three medication carts reviewed (first floor, back cart). Findings include: A review of facility policy entitled Controlled Substances last reviewed on August 7, 2025, revealed that nursing staff must count controlled medications at the end of each shift. The policy further stated that the nurse coming on duty and the nurse going off duty must complete the count together and that both nurses are required to sign the record to verify accuracy. In addition, the policy directed that any discrepancies must be reported to the Director of Nursing Services immediately A review of controlled drug records (also known as narcotics are medications that are regulated by federal law due to their high risk of abuse or misuse) for the first-floor, back medication cart revealed multiple instances in which the required signatures verifying narcotic counts were missing: January 14, 2025, the off coming nightshift nurse failed to sign that the narcotic count was completed and correct,January 15, 2025, the nightshift on coming nurse failed to sign that the narcotic count was completed and correct, and the off coming night shift nurse failed to sign that the narcotic count was completed and correct,January 17, 2025, the off going evening nurse failed to sign that the narcotic count was completed and correct, andAugust 10, 2025, the oncoming evening nurse failed to sign that the narcotic count was completed and correct, and off coming evening nurse failed to sign that the narcotic count was completed and correct. An interview with Employee 2, licensed practical nurse, on August 14 ,2025, at approximately 9:00 AM, confirmed the narcotic sheets on the dates listed above were not signed by the oncoming and off-going nurses as required. The information was reviewed with the Director of Nursing on August 14, 2025, at approximately 10:30 A.M. The review confirmed that the facility had not consistently implemented its established procedures to ensure accurate documentation of controlled substances. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5 (f)(x) Clinical records. 28 Pa Code 211.10 (c)(d) Resident care policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, review of facility policy, review of manufacturer instructions, 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 on one of three medication carts (first floor, back cart).Findings include: A review of the facility policy titled Storage of Medications, last reviewed by the facility on August 7, 2025, revealed that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals and that all such drugs shall be returned to the dispensing pharmacy or destroyed. A review of manufacturer instructions for Humalog Kwik Pen, Basaglar Kwik Pen, and Humalog Insulin vials revealed that these medications must be stored in the refrigerator until ready for use. Once removed from refrigeration, the insulin vials and pens may be used for up to 28 days. After 28 days, they are to be discarded. On August 14, 2025, at approximately 9:00 A.M., an observation of the first floor, back medication cart was conducted in the presence of Employee 2, a licensed practical nurse. The cart contained a Humalog KwikPen that had been opened on July 5, 2025, a Humalog Insulin vial that had been opened on July 5, 2025, and a Basaglar KwikPen that had been opened on July 11, 2025. These insulin medications were opened and available for resident use despite being beyond the manufacturer's recommended 28-day discard date. An interview with Employee 2 at the time of the observation on August 14, 2025, at approximately 9:00 AM, revealed the above medications were beyond the manufacturer's recommended 28-day discard date, and the medications should have been removed from the medication cart and discarded. On August 14, 2025, at approximately 10:30 A.M., the above findings were reviewed with the Director of Nursing. The review confirmed that the facility had not adhered to manufacturer guidelines and facility policy regarding the acceptable storage and use-by dates for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211. 12(c)(d)(1)(5) Nursing services. 28 Pa Code 211.10 (c)(d) Resident care policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to ensure the availability of a functioning bed for all current licensed and certified resident beds on two of three resident care units, (first floor and second floor).Findings include: The facility is licensed and certified by the State and the Centers for Medicare & Medicaid Services (CMS) for a specific number of resident beds. The facility must provide residents with bedrooms that are appropriately furnished with a bed, mattress, and related equipment in accordance with the facility's license and certification. Licensed capacity, in plain terms, is the maximum number of residents the facility is legally permitted and expected to be accommodated at any given time. Beds must be physically present to demonstrate that the facility is able to provide immediate, safe, and appropriate accommodations for its licensed capacity, and not merely maintain bed space on paper. Observations made during an environmental tour August 14, 2025, at 11:30 A.M., multiple missing resident beds were observed on the first and second floor units, as follows: Resident room [ROOM NUMBER], licensed as a triple room, contained no bed for 104B.Resident room [ROOM NUMBER], licensed as a triple room, contained no bed for 106B.Resident room [ROOM NUMBER], licensed as a double room, contained no bed for 113B.Resident room [ROOM NUMBER], licensed as a double room, contained no bed for 116B. Resident room [ROOM NUMBER], licensed as a double room, contained no bed for 217B. These observations confirmed that the facility did not maintain the full complement of licensed and certified beds, as several licensed resident spaces were without a functioning bed and mattress. The missing beds were not stored elsewhere in the facility and therefore were not available for immediate use. A review of the findings with the Nursing Home Administrator on August 14, 2025, at approximately 12:00 p.m. was conducted and confirmed. 28 Pa Code 201.18(b)(1) Management. 28 Pa Code 205.20 Resident rooms.