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	06/30/2026

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical records, select facility policy, and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility for one resident out of 27 residents reviewed (Resident 115).Findings include: Review of the facility's Restorative Nursing Programs Policy, last reviewed April 30, 2026, revealed that the facility will provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practical level. Further review of the policy revealed that all residents will receive maintenance nursing services as needed by certified nursing assistants. A review of the clinical record for Resident 115 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 hemiplegia (severe weakness or paralysis) and hemiparesis (loss of muscle function on one side of the body). A review of Resident 115's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated April 9, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 02 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of the clinical record indicated that physical therapy services were provided to Resident 115 from March 22, 2025, through April 18, 2025. A review of the physical therapy Discharge summary dated [DATE], revealed physical therapy discharged the resident from skilled therapy services and recommended referral to the facility's Restorative Nursing Program (RNP) to maintain the resident's functional abilities. The discharge summary directed staff to provide range-of-motion exercises through all planes of movement, 10 repetitions for two sets, for approximately 15 minutes daily. A review of a physician's order dated September 29, 2025, directed staff to provide active-assisted (resident performs the movement with assistance from another person) to passive range-of-motion (the movement is performed entirely by another person without assistance from the resident).exercises through all planes of movement, 10 repetitions for two sets, for approximately 15 minutes daily. A review of Resident 115's electronic task report (a summary of scheduled and completed resident-centered care tasks), Documentation Survey Report v2, and Medication Administration Record revealed no documented evidence that the restorative ambulation program had been implemented. An interview with the Director of Nursing on June 30, 2026, at 11:30 AM, confirmed the facility failed to consistently implement the planned restorative nursing program for Resident 115 as recommended by physical therapy to maintain the resident's functional abilities and deter declines to the extent possible and to ensure the resident's goals for ambulation were met. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12(c)(d)(5) Nursing services.

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
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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, weight records, and staff and resident representative interviews, it was determined the facility failed to ensure residents maintain acceptable parameters of nutritional status to the extent possible for three of 27 residents reviewed (Residents 13, 106, and 9). Findings include: Review of the facility weight policy last reviewed on April 30, 2026, indicated that resident weights are obtained routinely to monitor parameters of nutrition. Each individual's weight will be determined upon admission or readmission to the facility, weekly for the first four weeks after admission or readmission, and monthly, or as needed. If there is a weight loss or weight gain of 5 or more pounds, a reweight will be obtained. If the weight change is accurate after the reweight, the physician, registered dietitian, and the resident's responsible party (or the resident if appropriate) will be notified. The resident's weight loss will be reviewed the following day in the clinical meeting with the interdisciplinary team. Review of a facility policy entitled Nutritional Assessment, last reviewed by the facility on April 30, 2026, revealed it is the facility's policy to conduct a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, for each resident. The registered dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. The policy indicated individualized care plans will be developed that address or minimize to the extent possible the resident's risk of nutritional complications. Review of Resident 13's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and hypertension (blood pressure that is higher than normal). Review of Resident 13's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 5, 2026, revealed that Resident 13 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates no cognitive impairment). Review of the resident's weight record revealed that on May 26, 2026, the resident weighed 131 pounds; on June 7, 2026, the resident weighed 130 pounds; and on June 10, 2026, the resident weighed 107.8 pounds. A weight warning note by the registered dietician dated June 13, 2026, recorded the last available weight as 107.8 pounds on June 10, 2026, and documented that the resident may have lost 22.2 pounds (17.1 percent) in three days. The note further indicated that the resident was consuming more than 50 percent of meals and taking Ensure (nutritional beverage supplement) twice daily, making it unlikely that the resident had lost such a large amount of weight in that short period. The registered dietitian recommended that nursing staff obtain a reweight. Clinical record review revealed no documented evidence that a reweight was obtained as recommended by the registered dietitian for Resident 13. Following surveyor inquiry, the resident was reweighed on June 28, 2026, and weighed 108 pounds. Further review of the clinical record revealed no documented evidence that the physician or resident was notified of the possible weight loss. Review of findings with the registered dietitian on June 29, 2026, at 1:30 PM confirmed that Resident 13's weight monitoring was not carried out according to the facility's Weight Policy. Clinical record review revealed Resident 106 was admitted to the facility on [DATE], with diagnoses including Parkinsonism (a term for a group of neurological disorders that cause movement-related problems, primarily slowed movements, muscle stiffness, and tremors), dementia (a decline in mental abilities, such as memory, reasoning, and communication, that is severe enough to interfere with daily life), and dysphagia (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(difficulty swallowing). Review of Resident 106's quarterly MDS dated [DATE], revealed Resident 106 was severely cognitively impaired with a BIMS score of 7 (a score of 0 through 7 indicates severe cognitive impairment). Review of Resident 106's care plan dated October 14, 2025, identified the resident was at risk for altered nutritional status. The care plan goal was for the resident to consume adequate nutritional intakes to maintain nutritional status without significant weight change. Planned interventions included monitoring, documenting, and reporting any signs or symptoms of dysphagia; providing adaptive equipment as ordered; providing a fortified mechanical soft chopped diet and nectar thickened liquids; providing oral nutrition supplementation as ordered; obtaining weights as ordered; and having the registered dietitian make recommendations as needed. During an interview on June 27, 2026, at 11:10 AM, Resident 106's spouse expressed concern regarding the resident's declining meal intake, stating, I noticed he's not eating as much, and it really concerns me. Review of Resident 106's weight record revealed the following: May 1, 2026: 168.2 poundsJune 1, 2026: 161.0 poundsJune 2, 2026: 161.0 pounds (re-weight, confirming a 7.2-pound weight loss in one month) According to facility policy, the confirmed weight loss of 5 or more pounds requires physician, registered dietitian, and responsible party notification as well as interdisciplinary team review. However, review of the clinical records revealed no documented evidence the facility notified the physician, registered dietitian, or Resident 106's responsible party of the confirmed 7.2-pound weight loss. There was also no documented evidence that the interdisciplinary team reviewed the resident's significant weight loss or evaluated the need for additional nutritional interventions. During an interview on June 30, 2026, at 9:24 AM, the registered dietitian confirmed the facility failed to identify Resident 106's significant weight loss. At the surveyor's request, staff obtained another weight on June 30, 2026, at 10:40 AM, which documented the resident's weight as 150.4 pounds, representing an additional 10.6-pound weight loss since the June 2, 2026, confirmed weight. There was no documented evidence that the facility recognized or acted upon Resident 106's weight loss identified on June 1, 2026, and confirmed by reweighing on June 2, 2026. There was no documented assessment to determine the cause of the continued weight loss, no evidence additional nutritional support or interventions were implemented to prevent further decline, and no evidence the physician, registered dietitian, and resident representative were informed as required by facility policy. Additionally, the facility failed to demonstrate ongoing monitoring of the resident's nutritional status and weight in accordance with its policies despite the resident's progressive neurological condition and known risk factors for nutritional decline. As a result, Resident 106 experienced continued significant weight loss from 168.2 pounds on May 1, 2026, to 150.4 pounds on June 30, 2026, a total loss of 17.8 pounds without documented timely evaluation or intervention. Clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that included severe protein malnutrition (a condition caused by a severe, prolonged deficiency of nutrients, primarily protein and calories) and dementia. Review of Resident 9's admission Minimum Data Set assessment (MDS,) dated May 21, 2026, revealed that Resident 9 had a BIMS score of 99 (a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section). The assessment indicated Resident 9 had short-term and long-term memory problem, and the ability to make decisions about tasks of daily life was severely impaired. Clinical record review revealed a care plan indicating Resident 9 was at risk for altered nutritional status initiated on May 19, 2026. Interventions implemented to ensure Resident 9 consumed adequate nutritional intakes to maintain nutritional status include providing a diet as ordered (fortified meals) and weighing the resident as ordered, initiated on May 19, 2026. Clinical record review of Resident 9's weights revealed the following: May 16, 2026: 98.0 poundsMay 30, 2026: 94.2 poundsJune 6, 2026: 94.2 pounds A progress note dated June 13, 2026, at 3:17 PM indicated Resident 9 refused weekly weight on this date. During an interview on June 28, 2026, at 1:30 PM, the Registered Dietician (RD) was unable to provide documented evidence that Resident 9 was weighed weekly in accordance with facility policy. The RD confirmed that Resident 9 was at risk for malnutrition and continued weight loss since admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed, following inquiries made during the survey, Resident 9 was reweighed. Resident 9 weighed 98.0 pounds on May 16, 2026, and weighed 90.6 pounds on June 28, 2026, indicating a 7.4-pound, or 7.5%, significant weight loss in 43 days. Nutritional note dated June 29, 2026, at 10:44 AM revealed the resident had a body mass index (value derived from weight and height to screen for underweight. overweight or obesity) of 18.3 (underweight optimum range 18.5-24.9) and had significant weight loss over 30 days. New recommendations indicated to monitor weights weekly. Following inquiries made during the survey, physician's orders for Resident 9 to receive 4.0 ounce health shakes at meals were initiated on June 29, 2026. The facility failed to demonstrate ongoing monitoring of Resident 9's nutritional status and weight in accordance with its policies despite the resident's known risk factors for nutritional decline. As a result, Resident 9 experienced continued weight loss from 98.0 pounds on May 16, 2026, to 94.2 pounds on May 30, 2026, and to 90.6 pounds on June 28, 2026, a total loss of 7.4 pounds without documented timely evaluation or intervention. During an interview on June 30, 2026, at 10:30 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The facility failed to ensure residents maintained acceptable parameters of nutritional status to the extent possible for residents 9, 13, and 106. The facility failed to timely identify, evaluate, and implement interventions for significant weight loss for Residents 9 and 106, resulting in continued weight loss without documented assessment or intervention. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to consistently provide necessary services to meet the behavioral health needs for two of 27 residents reviewed (Residents 8 and 61).Findings include: A review of the facility's Behavioral Health Services policy, last reviewed April 30, 2026, indicated it is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning), bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of Resident 8's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 5, 2026, revealed that Resident 8 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates cognition is intact). A review of Resident 8's comprehensive care plan, initiated September 30, 2025, revealed the resident was at risk of changes in their mood related to their diagnoses of major depressive disorder, anxiety, and adjustment disorder, and interventions included psychiatric consult and treatment as ordered. A review of a psychiatric services consultant note dated March 23, 2026, revealed the consultant recommended therapy services for treatment of anxiety and depression, with follow-up to occur within 45 to 60 days. A review of a progress note from a Licensed Professional Counselor (LPC) dated April 22, 2026, revealed the resident was seen at their bedside to conduct a follow-up session for talk therapy and assessment for elevated behaviors and recommended follow-up on May 21, 2026. However, there was no documented evidence that Resident 8 received follow-up psychiatric or psychological services as of the survey ending June 30, 2026. A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of Resident 61's Quarterly MDS dated [DATE], revealed that Resident 61 had moderately impaired cognition with a BIMS score of 9 (a score of 8 through 12 indicates moderate cognitive impairment). A review of Resident 61's comprehensive care plan, initiated January 19, 2024, revealed the resident was at risk of changes in their mood related to their diagnosis of depression and experienced episodes of anxiety, and interventions included psychological consultation and treatment and LPC consultation as needed. A review of a psychiatric services consultant note dated April 14, 2026, revealed the consultant recommended therapy services for treatment of anxiety, depression, insomnia (a sleep disorder), and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) with follow-up to occur within 14 to 21 days. A review of a progress note from an LPC dated April 20, 2026, revealed the resident was seen at their bedside to conduct a follow-up session for talk therapy and assessment for elevated behaviors and recommended follow-up on May 20, 2026. However, there was no documented evidence that Resident 61 received follow-up psychiatric or psychological services as of the survey ending June 30, 2026. During an interview with the Director of Nursing on June 30, 2026, at 11:00 AM, it was (continued on next page)

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	395288	A. Building B. Wing	06/30/2026

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed that Resident 8 and Resident 61 did not receive the recommended follow-up psychiatric and psychological services. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395288	A. Building B. Wing	06/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, review of the facility's infection control tracking logs, facility policy, and staff interviews, it was determined the facility failed to maintain a comprehensive infection control program to monitor the development and spread of infections within the facility, including tracking of infections for three out of 27 residents reviewed (Residents 50, 122, and 140).Findings include: Review of the facility's Infection Prevention and Infection Control Plan, indicated as last reviewed by the facility on April 30, 2026, revealed facility leadership is committed to resident safety, providing quality healthcare services, and preventing disease transmission for those that provide support or receive services at the facility. The policy indicated the infection preventionist will provide ongoing, facility-wide outcome and process surveillance of healthcare-associated infections. The policy defined outcome surveillance as a systemic method of collecting, consolidating, and analyzing data concerning a disease or event, followed by dissemination of the information with a goal of improving outcomes. Healthcare-associated infection outcome surveillance incorporates several approaches to minimize risks and control the spread of infections. A review of the facility's infection control data conducted during the survey ending June 30, 2026, revealed the facility's infection control tracking did not reflect evidence of a functional tracking system to monitor and investigate causes of infection and manner of spread. There was no documented evidence of a functional system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. Clinical record review revealed Resident 140 tested positive for SARS-CoV-2 (the virus that causes COVID-19, a contagious respiratory illness) on December 19, 2025. Resident 50 tested positive for SARS-CoV-2 (the virus that causes COVID-19) on January 15, 2026. Resident 122 tested positive for SARS-CoV-2 (the virus that causes COVID-19) on March 3, 2026. During an interview on June 30, 2026, at 9:35 AM, the infection preventionist (IP) was unable to provide any documented evidence of facility tracking or analysis of healthcare-associated infections from November 1, 2025, through March 16, 2026. The IP was unable to provide documented evidence of HAI surveillance, including tracking and monitoring of Residents 50, 122, or 140's SARS-COVID-19 infections. There was no documented evidence of detailed data collection that could be used by the facility to track infections and to identify any potential trends contained in the tracking data from November 1, 2025, through March 16, 2026. There was no documented evidence at the time of the survey that, based on the available tracking data, the facility had identified any possible trends to implement specific interventions to prevent the spread of any of the infections during the above date range. There was no documented evidence from November 1, 2025, through March 16, 2026, that the facility was compiling data and evaluating the data to determine what could be done to prevent the spread or recurrence of infection. The facility failed to include the necessary details to conduct routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., healthcare-associated infections (HAIs) and community-acquired), infection risks, and communicable disease outbreaks and to maintain or improve resident health status and to track staff for adherence to infection control policies and procedures and the potential need for corrective action. During an interview on June 30, 2026, at 10:30 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was unable to provide documented evidence of healthcare-associated infection tracking, trending, or data analysis records from November 1, 2025, through March 16, 2026. The facility failed to maintain a comprehensive program to monitor the development and spread of infections within the facility, including tracking of infections for residents 50, 122, and 140.28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.

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	395288	A. Building B. Wing	06/30/2026

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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 review of clinical records. select facility policy, observations, and staff interviews, it was determined that the facility failed to make reasonable accommodations to meet one resident's assessed need for assistive positioning devices while seated in a wheelchair, for one of 27 residents reviewed (Resident 12). Findings include: Review of the facility policy titled Positioning last reviewed by the facility on April 30, 2026, revealed residents will be screened for positioning needs by Occupational Therapy or Physical Therapy. The policy indicated a positioning evaluation will be completed and included in the medical record. Treatment is to focus on providing necessary equipment and implementing a 24-hour positioning plan. The policy further required documentation of positioning recommendations, the 24-hour positioning plan, and education provided to the resident, family, or caregivers Review of clinical records revealed Resident 12 was admitted to the facility on [DATE], with diagnoses to include adult failure to thrive (a syndrome of physical, cognitive and functional decline affecting older adults with multiple chronic illnesses), bipolar disorder (mental health condition that causes extreme, cyclical shifts in mood, energy, activity levels, and concentration), and post-traumatic stress disorder (a mental health condition that can develop in individuals who have experienced or witnessed a shocking, terrifying, or life-threatening event. These individuals continue to experience severe distress, fear, and stress long after the traumatic event has ended). A review of Resident 12's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 7, 2026, revealed Resident 12 was moderately cognitively impaired 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 through 12 indicates moderate cognitive impairment). The assessment also indicated the resident required total staff assistance with transfers. Observation on June 28, 2026, at 12:40 PM revealed Resident 12 seated in a high-back wheelchair (high backrest used for additional support for head, neck and shoulders) with both legs and feet dangling 16-18 inches above the floor without support. Review of the clinical record revealed Resident 12 had a documented height of 55 inches tall (4 feet 5 inches), reflecting the resident's shorter stature. Review of an Occupational Therapy treatment note dated April 22, 2026, revealed Occupational Therapy completed a wheelchair analysis to evaluate the resident's body alignment and functional positioning. The evaluation documented that the resident was provided a new high-back wheelchair with bilateral leg rests with a foot/calf board (a solid, padded panel that attaches to the front of a wheelchair to support the lower legs and feet) to provide increased bilateral lower extremity (leg) support. Review of the Occupational Therapy Discharge summary dated [DATE], indicated Resident 12 achieved the long-term goal of maintaining an upright seated posture for six hours using adaptive equipment and/or devices. However, the discharge summary failed to identify the specific adaptive equipment and positioning devices required to achieve and maintain that goal. A second observation conducted on June 29, 2026, at 1:00 PM revealed Resident 12 sitting in the dining room in the same high-back wheelchair with both legs unsupported and dangling 16-18 inches above the floor. Employee 3 (Certified Occupational Therapy Assistant) observed the resident's positioning and confirmed the wheelchair was missing the legs rests and foot/calf board. Employee 3 also confirmed the positioning devices were not present in the resident's room. During an interview on June 29, 2026, at 1:15 PM the Director of Rehab (DOR) stated Occupational Therapy evaluated Resident 12's seating and positioning needs and provided the resident with a high-back wheelchair, bilateral leg rests, and foot/calf board because the resident's feet were unable to touch the floor. The DOR stated a shorter wheelchair was not trialed because it would prevent the resident from reaching the dining room table during meals. The DOR provided a Staff Education Report dated May 21, 2026, documenting Occupational Therapy educated two staff members regarding Resident 12's positioning needs and use (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the high-back wheelchair with leg rests and foot/calf board for optimal positioning. Despite Occupational Therapy identifying the resident's need for the leg rests and foot/calf board and providing staff education regarding their use, the DOR confirmed there was no documented evidence these positioning devices were incorporated into the resident's care plan, physician orders, or Kardex system (a nursing information system used to obtain up-to-date specific care information for each resident) to ensure all staff consistently provided the necessary equipment. The facility failed to communicate and implement the resident's assessed need across disciplines, resulting in staff not consistently accommodating the resident's identified positioning needs while out of bed. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(d)(3)(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	06/30/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to consistently implement planned safety interventions for one resident (Resident 61) and failed to prevent unsecured medications from being at bedside, creating a potential accident hazard, for one resident (Resident 115) out of 27 residents reviewed. Findings include: Review of the facility's policy entitled Elopements and Wandering Resident, last reviewed April 30, 2026, revealed it is the policy to ensure that residents who exhibit wandering behavior and are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team and monitor the implementation of interventions, respond to interventions, and document accordingly. A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a condition in which excessive worry cause clinically significant distress or impairment in social, occupational, or other areas of functioning) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of Resident 61's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 10, 2026, revealed that Resident 61 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 through 12 indicates moderate cognitive impairment). A review of Resident 61's comprehensive care plan, initiated January 19, 2024, revealed the resident was an elopement risk and wander risk with interventions of a Wander Guard bracelet (an electronic monitoring device used to alert staff when a resident at risk for wandering or elopement approaches an exit) worn on the left ankle. A physician order dated March 4, 2024, directed staff to maintain a Wander Guard bracelet on the resident's left ankle and required staff to verify placement and proper functioning every shift. A review of an elopement risk assessment completed on May 21, 2024, identified Resident 61 as being at moderate risk for elopement. A review of the June 2026 Task Administration Record (TAR) revealed staff consistently documented that Resident 61 was wearing a Wander Guard device on the left ankle. However, direct observation conducted on June 27, 2026, at 11:45 PM revealed no Wander Guard device present on the resident's left ankle or any other extremity. Employee 2, Licensed Practical Nurse (LPN), confirmed the absence of the device during the observation and was unable to locate the Wander Guard within the resident's room. During an interview on June 28, 2026, at 1:30 PM, the Director of Nursing reviewed the above findings and confirmed the facility failed to consistently implement and monitor Resident 61's planned elopement prevention interventions, including maintenance and presence of the Wander guard device. Review of the facility's Medication Storage Policy, last reviewed April 30, 2026, revealed the facility will ensure all medication that are contained on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. A review of the clinical record for Resident 115 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 hemiplegia and hemiparesis (severe weakness or paralysis loss of muscle function) on one side of the body). A review of Resident 115's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated April 9, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 02 (Brief (continued on next page)

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	395288	A. Building B. Wing	06/30/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). An observation conducted on June 27, 2026, at 11:00 AM revealed a clear plastic disposable drinking cup that had a white paste in it and a disposable spoon, which was present on the nightstand table next to the resident's bed. During an interview on June 27, 2026, at 11:30 AM, Employee 4, Nurse Aide, stated that the cream was a mixture of zinc oxide and A and D ointment (both are topical skin protectants used to prevent and treat minor skin irritation and not for consumption) and was at the bedside for the nurse aides to use as needed during incontinence care. A clinical record review during the survey ending on June 30, 2026, revealed that Resident 115 did not have an order for either cream. During an interview on June 28, 2026, at 1:00 PM, the Director of Nursing was informed of and reviewed the above findings related to nursing staff leaving medicated creams and ointments at residents' bedsides and confirmed that staff should not leave medicated cream at the bedside. 28 Pa. Code 201.18 (b) (1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d) (1) (3) (5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical records and select policy reviews, observations, and staff interviews, it was determined the facility failed to provide oxygen equipment in accordance with physician orders for one of 27 sampled residents (Resident 7).Findings include: Review of the facility's oxygen administration and tracheostomy care policies, reviewed April 30, 2026, revealed that oxygen will be administered under the orders of a physician. The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care, and suctioning. Based on resident assessment, attending physician orders, and professional standards of practice, the facility, in collaboration with the resident or resident's representatives, will develop a care plan that includes appropriate interventions for respiratory care. Clinical record review revealed that Resident 7 had diagnoses that included respiratory failure and tracheostomy (a surgically created opening in the front of the neck into the windpipe to create an airway with a tube placed in this opening to keep it open for breathing). A review of Resident 7's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 8, 2026, revealed that Resident 7 had moderate cognitive impairment 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 through 12 indicates moderate cognitive impairment). Review of current physician orders revealed the resident required supplemental oxygen at 6 liters per minute and that the amount of oxygen was to be titrated (increased or decreased) to maintain oxygen saturations (the percentage of red blood cells in the blood carrying oxygen, with normal levels for healthy individuals being 95 to 100%) greater than 92%. This was to be measured in the facility utilizing a pulse oximeter (a device that can be attached to the finger or toe to measure the percentage of blood saturation). Observation of the resident's oxygen administration device on June 28, 2026, at 10:30 AM and June 29, 2026, at 11:00 AM revealed the facility's current oxygen setup was not designed so that the resident's oxygen could be titrated, as it required a fixed oxygen flow rate. Closer inspection of the fixed rate of the oxygen device indicated that a flow rate of 8 liters per minute was to be utilized with this device; however, the oxygen flow rate set by the facility was at 6 liters per minute and did not correlate with the appliance chosen. It was not until surveyor notification that the physician was contacted and adjustments were implemented so the oxygen device correlated with physician orders and resident needs. An interview with the Nursing Home Administrator on June 30, 2026, at 9:00 AM revealed that the facility contacted the physician and consulted with a respiratory therapist to modify the oxygen setup to correlate with physician orders. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and resident and staff interviews, it was determined the facility failed to comprehensively monitor and implement appropriate interventions for new onset and worsening pain in accordance with physician orders and facility policy for one of 27 residents reviewed (Resident 105).Findings include: Review of the facility's Pain Assessment and Management policy, last reviewed April 30, 2026, revealed the purpose of the policy is to ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The policy indicated the facility will reassess residents' pain management at established intervals for effectiveness. If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. Clinical record review revealed Resident 105 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (a condition where the lungs fail to adequately oxygenate the blood or remove carbon dioxide, leading to insufficient oxygen to meet the body's needs) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). Review of Resident 105's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 3, 2026, revealed that Resident 105 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates cognition is intact). A physician's order for acetaminophen 325 milligram (mg) tablets, initiated on June 2, 2026, directed staff to administer 650 mg by mouth every six hours as needed for a pain level of 1 through 5, based on a standard 0 to 10 pain rating scale, where 0 indicates no pain and 10 indicates the worst pain imaginable. A nursing progress note dated June 10, 2026, revealed that at approximately 4:30 AM the resident activated the call bell and was observed halfway off the bed while attempting to transfer to a wheelchair. The resident stated she struck her ankle on the wheelchair while attempting to go to the bathroom. The resident was able to move the foot and ankle and wiggle the toes. The resident reported pain rated as 10 out of 10 on the standard pain scale, indicating the worst pain imaginable. Staff applied ice, elevated the foot, and notified the nursing supervisor. At 5:40 AM, the resident reported the pain continued and radiated (spread) up the leg and requested acetaminophen. Review of a medication administration record (MAR) dated June 2026 revealed Resident 105 was administered acetaminophen 650 mg for a pain level 10 on June 10, 2026. The MAR indicated on June 10, 2026, at 5:26 AM that the acetaminophen 650 mg was ineffective for treating Resident 105's pain. Review of Resident 105's vital signs in the electronic health record pain level tab revealed the following recordings of pain on June 10, 2026: 4:30 AM 8 out of 105:26 AM 10 out of 106:50 AM 10 out of 10 A late-entry progress note dated June 10, 2026, at 9:00 AM (entered into the clinical record on June 14, 2026, at 2:54 AM) documented that Resident 105 was assessed at the bedside for complaints of left ankle pain. The note documented that the resident reported pain and difficulty walking on the left ankle. The assessment identified bruising and swelling of the left ankle. The assessment and plan documented left ankle pain and included orders for a left ankle X-ray, physical therapy and occupational therapy as needed, orthopedic follow-up as needed, acetaminophen, baclofen (a medication used to relieve muscle spasms), and continued monitoring. A physician's order dated June 10, 2026, at 9:30 AM directed staff to obtain an X-ray of Resident 105's left ankle for complaints of pain. A review of the Pain Evaluation assessment dated [DATE], at 9:33 AM (entered into the clinical record on June 12, 2026, at 12:35 PM) documented that Resident 105 rated the left ankle pain as 8 out of 10 on a standard pain scale. The assessment documented that the resident reported the pain hurts even more (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and identified ice, elevation, and acetaminophen as measures that relieved the pain. A review of the mobile radiology report revealed that Resident 105 underwent a left ankle X-ray on June 10, 2026, at 4:51 PM. The report, issued on June 10, 2026, at 7:06 PM identified an acute nondisplaced [NAME] Type C fracture (a recent ankle fracture located above the ligaments that stabilize the two lower leg bones, with the broken bone remaining in its normal position). A nursing progress note dated June 10, 2026, at 11:46 PM documented that three emergency medical services personnel transferred Resident 105 to the local emergency department for evaluation and treatment of the left ankle fracture. The note further documented that, at the time of transfer, the resident continued to report left ankle pain rated as 8 out of 10. A review of the emergency department after-visit summary dated June 10, 2026, documented that the resident sustained a closed fracture of the left fibula (the smaller bone of the lower leg). The emergency department applied a splint and administered hydrocodone-acetaminophen 5 mg/325 mg (a combination opioid and non-opioid pain medication). During a telephone interview conducted by the surveyor on June 29, 2026, at 12:30 PM Resident 105 stated that she fell while walking to the bathroom at approximately 4:30 AM on June 10, 2026. The resident stated that she struck her ankle against a wheelchair, fell to the floor, and staff assisted her back to bed and administered acetaminophen. The resident stated that she remained in severe pain until she was transferred to the hospital at approximately 11:30 PM. The resident further stated she was frustrated because she believed her pain was not adequately addressed while she waited for the X-ray results and transfer to the hospital. During an interview on June 29, 2026, at 1:55 PM, Employee 1, Registered Nurse Supervisor (RNS), stated that at approximately 11:00 PM on June 10, 2026, she contacted the mobile radiology provider to obtain the results of Resident 105's ankle X-ray. Employee 1 stated that the radiology provider acknowledged a delay in reporting the results. Employee 1 stated that, after receiving the report confirming a fracture, she notified the on-call physician, informed the resident of the results, and initiated transfer to the emergency department. During an interview on June 30, 2026, at 10:30 a.m., the above findings were reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence demonstrating that the facility performed ongoing assessments of Resident 105's pain or implemented additional pain management interventions between the resident's injury at approximately 4:30 AM on June 10, 2026, and the transfer to the emergency department at approximately 11:46 PM that same day, after the fracture was confirmed. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, payor source data, and resident and staff interviews, it was determined the facility failed to ensure timely and necessary dental services for one resident who is a Medicaid recipient (Resident 13) out of 27 residents reviewed.Findings include: Review of the facility's Dental Services policy, last reviewed April 30, 2026, indicated it is the policy of the facility to assist residents in obtaining routine and emergency ancillary services as needed. The policy defined routine dental services as annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs (x-ray) as needed, dental cleaning, and limited prosthodontic procedures such as taking impressions for dentures and fitting dentures. A review of Resident 13's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and hypertension (blood pressure that is higher than normal), and the resident's current payor source was Medicaid. A review of Resident 13's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 5, 2026, revealed that Resident 13 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates no cognitive impairment). During an interview on June 29, 2026, at 9:00 AM, the resident stated she has been waiting to receive dentures and did the impressions for them quite a while ago but has not heard any information about when she would receive her dentures and has not seen the dentist recently. Review of Resident 13's Dental Consult Sheet dated January 30, 2026, revealed the resident was seen by the dentist for a comprehensive exam, full mouth x-rays and took impressions and bite registration for complete upper and lower dentures. Review of Resident 13's Dental Consult Sheet dated March 30, 2026, revealed the resident was not seen because the resident was out of the facility in the hospital. Review of the clinical record revealed no further communication with the dentist regarding obtaining Resident 13's dentures, and the resident has not been seen by the dentist since impressions were obtained to receive dentures in January 2026. During an interview with the Director of Nursing on June 29, 2026, at 1:15 PM, the above findings were reviewed regarding the facility's failure to provide prompt dental services, as indicated in the facility policy. 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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies, observations, and resident and staff interviews, it was determined the facility failed to consistently implement and enforce its smoking policy for one of three residents who smoked (Resident 88).Findings include: A review of the facility's smoking policy, reviewed April 30, 2026, revealed that the facility does not allow smoking on the premises. Residents who are alert and oriented and able to leave the facility independently may smoke only while off the property on an approved leave of absence. The policy required that cigarettes, lighters, and other smoking materials be maintained by facility staff. Residents were not permitted to keep smoking materials on their person or in their rooms. Review of an Out on Pass/Going off Grounds document acknowledged by the resident on June 1, 2026, indicated that the Out on Pass leave of absence were permitted between 5:00 AM and 9:00 PM. A review of the clinical record revealed Resident 88 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD a chronic lung disease that restricts airflow and makes breathing difficult). A review of Resident 88's significant change Minimum Data Set assessment (MDS), a federally mandated standardized assessment process conducted periodically to plan resident care, dated May 3, 2026, revealed that Resident 88 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates intact cognition). A review of the clinical record revealed a physician's order dated May 28, 2026, authorizing Resident 88 to leave the facility independently on a leave of absence. Documentation revealed the resident signed the Out on Pass/Going Off Grounds acknowledgment on June 1, 2026. During an interview on June 28, 2026, at 11:00 AM, Resident 88 stated that after receiving the physician's order dated May 28, 2026, authorizing independent leaves of absence to smoke off the facility premises, and before signing the Out on Pass/Going Off Grounds acknowledgment on June 1, 2026, he routinely retained smoking materials, including a pack of cigarettes and a lighter, on his person while inside the facility. The resident stated staff did not request that he surrender the smoking materials, despite the facility's smoking policy requiring staff to retain residents' cigarettes and lighters. The resident further stated he was able to leave the facility to smoke without staff consistently enforcing the facility's established leave-of-absence hours. During an interview and observation on June 29, 2026, at 11:00 AM, Resident 88 showed the surveyor a pack of cigarettes and a lighter stored beneath the seat of his walker. The resident stated that upon returning to the facility from a leave of absence the previous evening, no staff member was present at the reception desk to receive his smoking materials; therefore, he placed the cigarettes on the desk with his name attached. The resident stated the facility did not establish designated hours for independent leaves of absence until June 1, 2026, and that staff did not explain the reason for the change. The resident further stated staff had recently begun requesting that smoking materials be surrendered; however, prior to that time, staff had not consistently requested that he turn in his cigarettes and lighter or asked whether he possessed smoking materials when leaving or returning to the facility. The resident stated the requirement to surrender smoking materials had not been consistently enforced. During an interview on June 30, 2026, the Nursing Home Administrator was unable to provide evidence demonstrating that staff consistently implemented the facility's smoking policy by collecting residents' smoking materials, ensuring residents did not retain cigarettes or lighters while inside the facility, or consistently enforcing the established leave-of-absence procedures for residents who smoked. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services