STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395295	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Murrysville Rehab and Nursing Center	3300 Logan Ferry Road Murrysville, PA 15668

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment by not maintaining a clean environment for three of three resident rooms (Residents R22, R50, and R65), and one of three resident wheelchairs (Resident R61).Findings Include: Review of the facility policy Homelike Environment dated 6/11/25, indicates the facility will provide an environment that is safe, clean, comfortable, and homelike. Review of the admission record indicated Resident R22 admitted to the facility on [DATE]. Observation on 3/16/26, at 9:19 a.m. Resident R22 was lying in bed. The resident's floor was sticky, stained with darkened areas, and covered in grime. Interview on 3/16/26, at 9:20 a.m. Licensed Practical Nurse (LPN) Employee E11 confirmed Resident R22's floor was sticky, stained with darkened areas, and covered in grime. Review of the admission record indicated Resident R50 admitted to the facility on [DATE]. Observation on 3/16/26, at 10:14 a.m. Resident R50 was sitting on the side of the bed. The resident's floor was sticky, stained with darkened areas, and covered in grime. The fall mat was sticky, had spots of dried liquids, and covered in grime. Interview on 3/16/26, at 10:15 a.m. LPN Employee E12 confirmed Resident R50's floor was sticky, stained with darkened areas, and covered in grime and the fall mat was sticky, had spots of dried liquids, and covered in grime. Review of the admission record indicated Resident R61 admitted to the facility on [DATE]. Observation on 3/18/26, at 10:26 a.m. Resident R61 was observed in the hallway in front of the television, sitting in a wheelchair. The wheelchair's seat and arm on the right side were completely covered in dried foods, crumbs, black grime, and were sticky. Interview on 3/18/26, at 10:27 a.m. Nurse Aide (NA) Employee E1 confirmed Resident R61's wheelchair seat and arm on the right side were completely covered in dried foods, crumbs, black grime, and were sticky. Review of the admission record indicated Resident R65 admitted to facility on 7/2/22. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Wecare at Murrysville Rehab and Nursing Center	3300 Logan Ferry Road Murrysville, PA 15668

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/17/26, at 11:15 a.m., Resident R65 was not in her room, however he resident's floor was sticky, stained with darkened areas, and covered in grime. The fall mat was sticky, had spots of dried liquids, and covered in grime. Interview on 3/17/26, at 11:19 a.m., LPN Employee E17 confirmed Resident R65's floor was sticky, stained with darkened areas, and covered in grime and the fall mat was sticky, had spots of dried liquids, and covered in grime. Interview on 3/18/26, at 10:30 a.m. the Nursing Home Administrator confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment by not maintaining a clean environment for three of three resident rooms (Residents R22, R50, and R65), and one of three resident wheelchairs (Resident R61). 28 Pa. code: 201.14 (b) Responsibility of licensee. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for five of eight residents (Residents R4, R11, R33, R80, and R85).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated September 2025, indicated the following:-Section N0415 - High-Risk Drug Classes: Use and Indication - Check if the resident is taking any medications by pharmacological classification.-Section M0100. Determination of Pressure Ulcer/Injury Risk - Check all that apply Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Review of the admission record indicated Resident R4 admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated the diagnoses of Parkinson's Disease (disorder of the nervous system that results in tremors), depression, and seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness). - Section N0415 K- failed to include anticonvulsant. Review of Resident R4's physician orders indicated Depakote Sprinkles (anticonvulsant medication) 125 mg (milligrams) give 375 mg by mouth two times a day. Review of Resident R4's Medication Administration Record (MAR) dated January 2026, indicated resident received Depakote sprinkles every day. Review of the admission record indicated Resident R11 admitted to the facility on [DATE]. Review of Resident R11's MDS dated [DATE], indicated the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section M0100 - Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, was not marked. M0210 - Does this resident have one or more unhealed pressure ulcers/injuries - was marked no. Section M0300 - C. Stage Three: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling was not marked as being present. Review of facility provided wound list on 3/16/26, indicated Resident R11 had developed a sacral wound on 8/15/25, and was classified as a Stage Three ulcer. Review of Resident R11's physician order dated 3/11/26, indicated to cleanse sacrum with saline, pat dry, apply Dakins (antiseptic solution) packed gauze, cover with 4 x 4 border every day and as needed. Review of Resident R11's Treatment Administration Record (TAR) dated January 2026, indicated resident received treatment daily to the sacral wound. Interview on 3/17/26, at 11:30 a.m. Licensed Practical Nurse (LPN) Employee E11 indicated Resident R11's wound developed last fall and LPN treats resident daily with wound care to the sacrum. Interview on 3/20/26, at 9:12 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed Resident R4's MDS was incorrect and the anticonvulsant was not marked as required and that Resident R11's MDS was incorrect and the Stage Three ulcer was not captured as required to reflect each residents' current needs. Review of the admission record indicated Resident R33 admitted to the facility 8/28/25. Review of Resident R33's MDS dated [DATE], indicated diagnoses diabetes mellitus (chronic condition that occurs when the body cannot properly use blood sugar (glucose) leading to high blood sugar levels) , dementia (syndrome characterized by the decline in cognitive function), and heart failure. Section N0415C failed to indicate an antidepressant was taken in the past seven days or since admission. Review of Resident R33's physician order dated 8/28/25, indicated Venlafaxine HCl (antidepressant medication) ER oral capsule Extended Release 24 hour 150 mg, give 1 capsule by mouth one time a day for depression. Review of Resident R33's MAR dated August 2025, and September 2025, indicated resident received Venlafaxine every day since 8/29/25. Review of the admission record indicated Resident R80 admitted to the facility 10/13/25. Review of Resident R80's MDS dated [DATE], indicated diagnoses Alzheimer's disease, failure to thrive, and heart failure. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section O0110K1 failed to indicate that hospice care had been provided while a resident. Review of Resident R80's physician order dated 10/13/25, indicated Heartland Hospice, Dx (diagnosis) End stage late onset Alzheimer's dementia. Effective date 7/11/25. Review of current plan of care initiated 10/13/25, updated 1/21/26, indicated that Resident R80 is receiving hospice services. Review of Resident R80's MDS's dated 10/16/25, and 3/2/26, Section O0110K1 indicated hospice care was provided while a resident. Review of the admission record indicated Resident R85 admitted to the facility 7/3/24. Review of Resident R85's MDS dated [DATE], indicated diagnoses diabetes mellitus, heart disease, and high blood pressure. Section N0350 Insulin failed to indicate the number of days that insulin injections were received during the last seven days. Review of Resident R85's physician order dated 11/5/25, indicated Humalog Kwikpen Subcutaneous Solution Pen-injector 100unit/ml (milliliter) (Insulin Lispro) inject 6 units subcutaneously before meals for DM2 (diabetes mellitus type 2). Review of Resident R85's physician order dated 7/10/24, indicated Lantus Solostar Subcutaneous Solution Pen-injector 100 units/ml, Inject 28 units subcutaneously at bedtime. Review of Resident R85's MAR dated March 2026, indicated resident received Insulin injections every day. Interview on 3/19/26, at 9:10 a.m., RNAC Employee E13 confirmed that Resident R80's MDS was incorrect and hospice was not captured as required and Resident R85's MDS was incorrect and insulin was not marked as required to reflect each residents' current needs. Interview on 3/20/26, at 9:19 a.m., RNAC Employee E13 confirmed Resident R33's MDS was incorrect and the antidepressant medication was not marked as required to reflect each residents' current needs. Interview on 3/20/26, at 10:00 a.m. the Director of Nursing (DON) confirmed that the facility failed to make certain that resident assessments were accurate for five of eight residents (Residents R4, R11, R33, R80, and R85). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for three of eight residents (Resident R4, R29, and R33).Findings include: Review of the facility policy Care Plans, Comprehensive Person-Centered dated 6/11/25, indicated the facility must develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs that is developed and implemented for each resident. Review of the admission record indicated Resident R4 admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/5/26, indicated the diagnoses of Parkinson's Disease (disorder of the nervous system that results in tremors), depression, and seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness). Review of Resident R4's current Medical Diagnoses list included evidence of a vagal nerve stimulator (involves using electrical pulses to stimulate the vagus nerve). Review of Resident R4's current physician orders and care plan, failed to include instructions for care and management of the vagal nerve stimulator. Review of the admission record indicated Resident R29 admitted to the facility on [DATE]. Review of Resident R29's MDS dated [DATE], indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), high blood pressure, and weakness. Review of Resident R29's physician order dated 1/21/26, indicated trazodone (antidepressant with off label for sleeplessness) every night at bed. Review of Resident R29's Medication Administration Record (MAR) dated March 2026, indicated resident received the trazodone each night of the month as ordered. Review of Resident R29's current care plan failed to include instructions for care and management of trazodone and insomnia (sleeplessness). Review of the admission record indicated Resident R33 admitted to the facility 8/28/25. Review of Resident R33's MDS dated [DATE], indicated diagnoses diabetes mellitus (chronic condition that occurs when the body cannot properly use blood sugar (glucose) leading to high blood sugar levels), dementia (syndrome characterized by the decline in cognitive function), and heart failure. Review of Resident R33's physician order dated 8/28/25, indicated Venlafaxine HCl (antidepressant medication) ER oral capsule Extended Release 24-hour 150 mg (milligrams), give 1 capsule by mouth (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one time a day for depression. Review of Resident R33's physician order dated 8/28/25, indicated Apixaban (anticoagulant medication) Oral tablet 5 mg (milligrams) give 1 tablet by mouth two times a day for Factor 5 Leiden mutation. Review of Resident R33's physician order dated 11/25/25, indicated Furosemide (diuretic medication) Oral tablet 20 mg, give 20 mg by mouth one time a day for leg swelling. Review of Resident R33's physician order dated 2/18/26, indicated Insulin Degludec Subcutaneous Solution 100 unit/ml (milliliter), inject 16 units subcutaneously at bedtime for DM2 (Diabetes mellitus type 2). Review of Resident R33's physician order dated 2/18/26, indicated Novolog Solution 100 unit/ml (Insulin Aspart) inject 10 unit subcutaneously in the morning for DM2 before breakfast. Review of Resident R33's physician order dated 2/18/26, indicated Novolog Solution 100 unit/ml (Insulin Aspart) inject 8 unit subcutaneously one time a day for DM2 before lunch. Review of Resident R33's physician order dated 2/18/26, indicated Novolog Solution 100 unit/ml (Insulin Aspart) inject 10 unit subcutaneously one time a day for diabetes before dinner. Review of Resident R33's MAR dated February 2026, and March 2026, indicated that above medications were given each day as ordered. Review of Resident R33's current care plan failed to include instructions for care and management of antidepressant, anticoagulant, diuretic, and insulin medication usage. Interview on 3/20/26, at 9:12 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed Resident R4's vagal nerve stimulator and Resident R29's trazodone for sleeplessness were not included in the comprehensive care plan as required; confirmed that Resident R33's antidepressant, anticoagulant, diuretic, and insulin medications were not included in the comprehensive care plan as required, and that the facility failed to develop care plans that included instructions to provide person centered care for three of eight residents (Resident R4, R29, and R33). 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel files and staff interview it was determined that the facility failed to complete annual nurse aid employee evaluations for four of five sampled records (Nurse aide (NA) Employees E1, E2, E3 and E4).Findings include: Review of employee personnel files on 3/18/26, at 9:00 a.m. indicated the following: Review of NA Employee E1's personnel record indicated a date of hire as 1/5/23. The last performance review completed annually was 2/23/25. Review of NA Employee E2's personnel record indicated a date of hire as 9/5/22. The last performance review completed annually was 2/23/25. Review of NA Employee E3's personnel record indicated a date of hire as 12/16/06. The last performance review completed annually was 1/6/25. Review of NA Employee E4s personnel record indicated a date of hire as 1/8/18. The last performance review completed annually was 1/3/25. Interview on 3/18/26, at 9:30 a.m. Assistant Director of Nursing Employee E16 confirmed the facility failed to complete annual nurse aid employee evaluations as required. 28 Pa. Code: 201.18(b)(1) Management.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to discard expired medical supplies and ensure all drugs and biologicals were stored under proper temperature controls for one of three of three medication carts (115 Hall Medication Cart, 136 Hall Medication Cart, and East Zone Two Medication Cart), and one of two Medication Rooms (West Side Medication Room). Findings include: Review of the facility policy Storage of Medications dated [DATE], indicated that discontinued, outdated, or deteriorated drugs are returned to the dispensing pharmacy or destroyed. During an observation on [DATE], at 9:19 a.m. the [NAME] Side Medication Room contained the following expired supplies:-Two tuberculin vials (detects tuberculosis) opened and not labeled with a date as required.-Multiple bags of urine culture tubes (30 tubes or greater) with expiration dates of [DATE]. During an interview on [DATE], at 9:20 a.m. Licensed Practical Nurse (LPN) Employee E11 confirmed that the two tuberculin vials were not dated and the above supplies were expired. During an observation on [DATE], at 9:25 a.m. of the 136 Hall Medication Cart contained the following expired supplies:-One package of Ipratropium bromide (an aerosolized medication to open airways) opened and not labeled with a date as required.-Two separate packages of Budesonide (an aerosolized medication to decrease inflammation) opened and not labeled with a date as required. During an interview on [DATE], at 9:40 a.m. LPN Employee E11 confirmed that the stated medications were opened and not labeled with a date as required. During an observation on [DATE], at 9:50 a.m. of the East Zone Two Medication Cart contained the following expired supplies:-One package of Ipratropium bromide (an aerosolized medication to open airways) opened and not labeled with a date as required.-Humalog vial of insulin (rapid acting insulin) opened and not labeled with a date as required.-Lispro Quick Pen (rapid acting insulin) opened and not labeled with a date as required.-Albuterol inhalation solution (opens airways) opened and not labeled with a date as required.-Fluticasone nasal spray (treats allergy like symptoms) opened and not labeled with a date as required. During an interview on [DATE], at 9:51 a.m. LPN E12 confirmed that the stated medications were opened and not labeled with a date as required. During an observation on [DATE], at 10:35 a.m. of the 115 Hall Medication Cart contained the following expired supplies:-Three separate Albuterol inhalation solutions (opens airways) opened and not labeled with a date as required.-Trelegy inhaler (reduces inflammation in airways) opened and not labeled with a date as required.-Timolol Eye Drops (reduces pressure in the eyes) opened and not labeled with a date as required. During an interview on [DATE], at 10:36 a.m. LPN Employee E18 confirmed that the stated medications were opened and not labeled with a date as required. Interview on [DATE], at 3:00 p.m. the Director of Nursing confirmed that the facility failed to discard expired medical supplies and ensure all drugs and biologicals were stored under proper temperature controls for one of three of three medication carts (115 Hall Medication Cart, 136 Hall Medication Cart, and East Zone Two Medication Cart), and one of two Medication Rooms (West Side Medication Room). 28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(2)(3) Nursing services.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy and documentation, resident and staff interview it was determined that the facility failed to address residents' council ongoing concerns for three of three months (March, February and January of 2026).Findings include: Review of facility policy Skilled Nursing Care Facility Policy Grievances Policy dated 6/11/25, indicated: Residents and their representatives must be assured that; They can submit grievances orally or in writing/. Their concerns will be investigated and responded to promptly. Review of facility documentation Resident Council Minutes indicated: Meeting Date 3/5/.26: Call bells were an issue and continued to be an issues since last meeting - call bells not being answered on time - wait time: (2 - 2 1/2 hours)(7 of 17 residents).Employees on phones while working (6 of 17 residents), and snacks not being offered or passed to residents (7 out of 17 residents). Meeting Date 2/5/26: call bells not being answered on time wait time (30 minutes - 2 1/2 hours - 5 out of 13 residents), Employees on phones while working (6 out of 13 residents), and snacks not being offered or passed to residents (8 out of 13 residents). Meeting Date 1/8/26: call bells not being answered, 9 of 18 residents, Employees on phones while working, (11 of 18 residents). During a resident group interview on 3/18/26, at 1:30 p.m. Residents indicated the above concerns of call bells not being answered timely, snacks not being passed or offered and employees on their phones are on-going, that residents continue to express the same concern as each meeting without resolution. During an interview on 3/20/26, at 9:05 a.m. Nursing Home Administrator confirmed that the residents' concerns during on resident council have been on going and that the facility failed to address resident council concerns for three of three months (January, February and March 2026). 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code:201.18(b)(1) Management.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide a Skilled Nursing Advanced Beneficiary Notice of Non-coverage (SNF-ABN) with the estimated amount of nursing services that will be charged for two of three residents (Residents R8, and R31). Findings include: Review of the facility policy Advanced Beneficiary Notices dated 6/11/25, indicated Medicare requires SNFs to issue the SNF-ABN to original Medicare beneficiaries prior to providing care that Medicare usually covers, but may not pay for. The SNF-ABN provides information to the beneficiary so that they can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. Review of the admission record indicated Resident R8 was admitted on [DATE]. Review of Resident R8's Minimum Data Set (MDS -a periodic assessment of care needs) dated 1/5/26, indicated the diagnoses of chronic obstructive pulmonary disease (COPD- a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), aphasia (difficulty swallowing), and hyperlipidemia (elevated fat levels within the blood). Review of Resident R8's SNF-ABN form dated 10/23/25, indicated beginning on 10/25/25, resident may have to pay out of pocket for this care if resident does not have insurance that may cover these costs. The facility estimates that these services will cost the resident $ Current PL per day/item or service. Review of the admission record indicated Resident R31 was admitted on [DATE]. Review of Resident R31's MDS dated [DATE], indicated the diagnoses COPD, high blood pressure, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R31's SNF-ABN form dated 11/26/25, indicated beginning on 11/29/25, resident may have to pay out of pocket for this care if resident does not have insurance that may cover these costs. The facility estimates that these services will cost the resident $ At current rate per day/item or service. Interview on 3/17/26, at 12:51 p.m. the Business Office Manager Employee E10 confirmed the facility failed to provide a Skilled Nursing Advanced Beneficiary Notice of Non-coverage (SNF-ABN) with the estimated amount of nursing services that will be charged for two of three residents (Residents R8, and R31). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(2)(3) Management

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Murrysville Rehab and Nursing Center	3300 Logan Ferry Road Murrysville, PA 15668

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview it was determined that the facility failed to make certain resident medication regimes were free from potentially unnecessary psychotropic medications for one of three residents (Resident R1).Findings include: Resident R1 was admitted on [DATE], and re-admitted to the facility on [DATE]. Review of Resident R1 MDS (minimum data set - a periodic assessment of resident needs) dated 1/8/26, indicated diagnosis of atrial fibrillation (irregular and often very rapid heart rhythm), and major depressive disorder recurrent (mood disorder that causes persistent feeling of sadness and loss of interest), and anxiety disorders (group of mental health conditions that cause fear , dread and other symptoms that are out of proportion to the situation) included on Resident R1 admit sheet. Review of Resident R1 clinical record MAR (medication administration record) for February 2026 indicated: Hydroxyzine Pamoate Capsule 50 MGGive 50 mg by mouth every 8 hours asneeded for Anxiety for 14 Days-Start Date-02/11/2026 2230-D/C Date-02/19/2026 1408 Lorazepam Oral Tablet 1 MG(Lorazepam)Give 1 mg by mouth every 8 hours asneeded for anxiety for 14 Days-Start Date-02/19/2026 1515-D/C Date-03/03/2026 1000 Review of the February MAR indicated: Hydroxyzine pamoate capsule 50 mg was given PRN (as needed) in February on the following days: 12, 13,14,15,16,17,18,and 19. Review of the February MAR indicated: Lorazepam oral table 1 mg was given PRN (as needed) in February on the following days: 20,21, and 28. Review of Resident R1 clinical records MAR for March 2026 indicated:Lorazepam OralTablet 1 MG(Lorazepam)Give 1 mg by mouthevery 8 hours asneeded for anxietyfor 14 Days-Start Date-02/19/2026 1515-D/C Date-03/03/2026 1000 Lorazepam OralTablet 1 MG(Lorazepam)Give 1 mg by mouthevery 8 hours asneeded for anxietyuntil 04/02/2026 23:59-Start Date-03/03/2026 1000 Review of the March MAR indicated Lorazepam oral tablet 1 mg was given PRN in March on the following days: 1, 2n,3,4,5,6,9,11,13,14,15,16,17, and 18. Review of the MAR failed to include what behaviors Resident R1 was experiencing and other attempts to relive potential behaviors prior to Resident R1 being given the psychotropic medication. Review of Resident R1 progress notes for February and March 2026 failed to include a description of behaviors, or non-pharmacological interventions that were given to Resident R1 prior to the psychotropic medications. During an interview on 3/20/26, at 9:15 a.m. Director of Nursing confirmed that the facilityfailed to provide non-pharmacological interventions prior to giving anti-anxiety medications to Resident R1. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the facility policy, clinical record review and staff interview, it was determined that the facility failed to accurately assess the nutritional status, and failed to update an individualized care plan to address the resident's specific nutritional concerns for two of five residents (Resident R4 and R49) records reviewed.Findings include: Review of facility's policy Nutritional Assessment, dated 6/11/25, indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and healthcare practioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a a change in condition that places the resident at risk for impaired nutrition. Once current conditions and risk factors for impaired nutritional are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risk for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. Individualized care plans shall address, to the extent possible:the identified causes of impaired nutrition;the resident's personal preferences;goals and benchmarks for improvement;time frames and parameters for monitoring and reassessment. Review of facility's policy Care Plans, Comprehensive Person-Centered, dated 6/11/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement on each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The interdisciplinary team reviews and updates the care plan:when there has been as significant change in the resident's condition;when the desired outcome is not met;when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. Review of facility's policy Resident Food Preferences dated 6/11/25, indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. When possible, staff will interview the resident directly to determine current food preferences based on the history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/5/26, indicated diagnoses of Parkinson's disease (a progressive neurological disorder characterized by the degeneration of nerve cells in the brain primarily affecting movement), dementia (syndrome characterized by the decline in cognitive function) and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as mania and depression). Section K0300 was coded a 2, which indicated that Resident R4 had a weight loss of 5% or more in the last month or weight loss of 10% or greater in the last six months. Section K0520C indicated that a mechanically altered diet was used within the last seven days, and Section K0520D indicated that a therapeutic diet was used in the last seven days. Review of Resident R4's current physician order dated 9/25/24, indicated a No Added Salt diet, with mechanical soft textures. Review of Resident R4's physician orders dated 2/21/25, indicated Dietary Health Shake one time a day for weight loss, lunch tray; Frozen supplement one time a day for weight loss, dinner tray; both were discontinued 2/6/26. Review of Resident R4's physician order dated 8/18/25, indicated MedPass (oral nutritional supplement) 2.0 three times a day for weight loss 60cc's (cubic centimeters); discontinued 2/6/26. Review of Resident R4's current plan of care, initiated 12/29/22, updated 1/16/26, revealed interventions to provide and serve supplements as ordered: Dietary Health Shake, Frozen dessert supplement and MedPass 2.0. Further review of care plan failed to establish nutritional focus and goals related to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mechanically altered and therapeutic diet use as identified on 1/5/26 MDS assessment. Review of Resident R4's nutritional progress notes failed to reveal clinical documentation by the Registered Dietitian and/or physician as to why Resident R4's nutritional supplements were discontinued on 2/6/26, due to a history of significant weight loss as identified on 1/5/26 MDS assessment. During an interview on 3/20/26, at 9:36 a.m., Registered Dietitian (RD) Employee E14 confirmed that Resident R4's care plan was not updated to remove discontinued oral nutritional supplements, and clinical nutrition notes failed to document reason for discontinuing Resident R4's oral nutritional supplement 2/6/26, with a history of significant weight loss. Review of the clinical record indicated Resident R49 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/16/26, indicated diagnoses cerebral infarction with aphasia (stroke with language disorder that affects communication ability), high blood pressure, and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as mania and depression).Section K0520C indicated that a mechanically altered diet was used within the last seven days. Review of Resident R49's physician order dated 9/25/24, indicated a regular diet, mechanical soft textures, large portions with dinner. Review of Resident R49's physician order dated 7/3/23, indicated 2 cal (calorie) supplement 60cc with meals; discontinued 2/6/26. During an observation on 3/17/26, at 12:00 p.m., Resident R49's lunch tray failed to contain all food items indicated to provide on Resident R4's lunch tray ticket (document that identifies resident's wants and needs based on diet order and individual preferences for each meal). Resident R4's lunch tray failed to contain 2 cookies, and 2 servings of entree/meat as indicated on tray ticket:MECH SOFT 2 each Assorted cookieMECH SOFT 2 x 3 oz (ounce) Sweet & Sour Chicken During an interview on 3/17/26, at 12:02 p.m., Corporate Dietary Consultant Employee E15 confirmed that Resident R49's lunch tray as observed failed to contain MECH SOFT 2 x Assorted cookies, and MECH SOFT 2 x 3oz Sweet & Sour Chicken as indicated on lunch tray ticket. Review of Resident R49's current plan of care initiated 11/12/25, updated 2/4/26, revealed interventions to provide and serve supplements as ordered: 2CAL MedPass BID. Further review of care plan failed to establish nutritional focus and goals related to mechanically altered diet use as identified on 2/16/26 MDS assessment. Care plan also failed to contain diet order/preference for large portions at dinner. Review of facility provide meal tray tickets, dated 3/17/26, revealed that Resident R49's preferences on meal tickets indicated double portion (2x) entrees at all 3 meals. Review of Resident R49's Nutrition assessment dated [DATE], failed to identify use and reason for large portions at dinner per diet order, as either part of therapeutic nutrition program or resident personal reference. During an interview on 3/18/26, at 12:47 p.m., RD Employee E14 revealed that Resident R49's meal tray tickets were inaccurate to reflect diet order instructions for large portions at dinner, confirmed that Resident R49's care plan was inaccurate for oral nutritional supplement which were discontinued, and failed to accurately assess Resident R49's nutritional status on 2/16/26, by failing to identify rationale for use of large portions at dinner. During an interview on 3/20/26, at 1:30 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON)confirmed that the facility failed to accurately assess the nutritional status and failed to update an individualized care plan to address the resident's specific nutritional concerns for two of five residents (Resident R4 and R49) records reviewed. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 211.12(d)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff and resident interview, it was determined that the facility failed to ensure Total Parenteral Nutrition (TPN) was administered consistent with professional standards of practice and in accordance with physician orders for one of three residents (R96). Findings include: Review of the facility policy Parenteral Nutrition dated 6/11/25, indicated the purpose of PN is to provide guidelines for the safe and aseptic administration of partial nutrition to residents who have a need for supplemental nutrition. (PN or TPN is a sterile pharmacy-prepared form of nutrition that is delivered through an intravenous route.) A physician's order is necessary for this treatment. The PN order should include the formula, total volume and rate of administration. Review of the admission record indicated Resident R96 admitted to the facility on [DATE], with the diagnoses of persistent small bowel obstructions (SBOs), small bowel mesenteric desmoid tumor (an abnormal mass of tissue. It forms when cells grow and divide more than they should or do not die when they are supposed to), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R96's physician order dated 1/8/26, indicated administer 2500 milliliters (ml) over 18hours. Infuse continuous over 18hours once daily at 74 ml/hr (ml/hour) for the first hour, 147 ml/hr for 16 hours, and then 74 ml/hr for the last hour via infusion pump intravenously (IV), Review of Resident R96's progress note dated 1/9/26, at 11:50 a.m. indicated Resident R96 on TPN for SBO. Registered Nurse was alerted that the IV pump was beeping and complete. TPN initiated on at 8:00 p.m. on 1/8/26. Resident received correct medication and concentration with a rate discrepancy. Provider notified. Review of facility provided Medication Incident form dated 1/9/26, indicated the TPN rate ordered at 147ml/hr for 16 hours was set at the rate of 174 ml/hr in error. Interview on 3/17/26, at 1:00 p.m. the Director of Nursing confirmed that the facility failed to ensure TPN was administered consistent with professional standards of practice and in accordance with physician orders for one of three residents (R96). 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R9).Findings include: Review of facility policy Trauma Informed Care and Culturally Competent Care dated 6/11/25, indicated: purpose: To address the needs of trauma survivors and/or re-traumatization. Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Trigger is a psychological stimulus that prompts recall of a previous traumatic event , even if the stimulus itself is not traumatic or frightening. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9 MDS (minimum data set - a periodic assessment of care needs), dated 1/14/26, indicated diagnosis of PTSD (a mental health condition that caused by an extremely stressful or terrifying event) and TBI (happens when a sudden, external, physical assault damages the brain). Review of Resident R9 care plan for PTSD identified that a traumatic event occurred, but failed to identify triggers for Resident R9's as related to PTSD. During an interview on 3/20/26, at 9:28 a.m. Director of Nursing confirmed that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R9. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to use proper hand washing to prevent cross contamination during a dressing change for one of three residents (Resident R11). Findings include: Review of the facility policy Handwashing/Hand Hygiene dated 6/11/25, indicated use alcohol-based hand rub containing at least 62% alcohol and/or soap and water before handling clean or soiled dressings, gauze pads, etc.; After handling used dressings, contaminated equipment, etc.; The use of gloves does not replace hand washing/hand hygiene. Review of the facility policy Wound Care dated 6/11/25, indicated wash and dry hands thoroughly. Put on clean gloves, loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Review of the admission record indicated Resident R11 admitted to the facility on [DATE]. Review of Resident R11's MDS dated [DATE], indicated the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Review of Resident R11's physician order dated 3/11/26, indicated to cleanse sacrum with saline. Pat dry, apply Dakins (antiseptic solution) packed gauze, cover with 4 x 4 border every day and as needed. During a dressing change observation on 3/17/26, at 11:30 a.m. Licensed Practical Nurse (LPN) Employee E11 washed their hands, applied new gloves and removed the old, soiled dressing. Nurse then removed the gloves, did not wash hands, and applied new gloves. Cleansed the wounds with saline and removed the gloves, did not wash hands, and applied new gloves to complete the dressing change. Interview on 3/17/26, at 11:35 a.m. LPN Employee E11 indicated washing the hands after each glove change would be a big waste of products. Interview on 3/17/26, at 11:40 a.m. the Director of Nursing confirmed the facility failed to use proper hand washing to prevent cross contamination during a dressing change for one of three residents (Resident R11). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.28 (b)(1)(e)(1) Management.28 Pa Code: 211.10 (d) Resident care policies.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for one of three shower chairs (Resident R82).Findings include: Review of the facility policy Assistive Devices and Equipment dated 6/11/25, indicated device condition and equipment are maintained on schedule and according to manufacturer's instructions. Defective or worn devices are discarded or repaired. Review of the admission record indicated Resident R82 admitted to the facility on [DATE]. Review of Resident R82's Minimum Data Set (MDS- a periodic assessment of care needs dated 12/29/25, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), Parkinson's Disease (disorder of the nervous system that results in tremors), and Bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Observation on 3/16/26, at 10:35 a.m. Nurse Aide (NA) Employee E1 was pulling Resident R82 backwards down the hall. Interview on 3/16/26, at 10:36 a.m. NA Employee E1 indicated being aware of not pulling resident backward; however, the wheels of the shower chair are all messed up and if staff push forward as required the chair drives out of control so it's easier to pull the chair backwards. Interview on 3/16/26, at 3:00 p.m. the Director of Nursing confirmed the facility failed to make certain that equipment was in safe operating condition for one of three shower chairs (Resident R82). 28 Pa Code: 201.14(a) Responsibility of licensee.