STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility provided documentation, review of policy and interview with staff, it was determined that facility did not ensure that training related to psychosocial needs/behavioral health needs was provided for nine of 10 employees reviewed. (Employee E17, E18, E19, E20, E21, E22, E23, E24, and E25)Findings include: Review of facility policy ?Behavioral - Mental Health Care - Substance Use Services,' revised March 19, 2025, revealed that Training: facility will provide an effective training program for all staff which includes training on behavioral health care and services, mental disorders, psychosocial disorders, PTSD, and/or SUD, that is appropriate and effective as determined by staff need and the facility assessment; facility staff includes all facility staff (direct and indirect care functions), contracted staff, and volunteers . Further review of policy revealed that a behavioral health training as determined by the facility assessment should include, at a minimum, the competencies and skills necessary to provide the following: Person-centered care and services that reflect the resident's goals for care;Interpersonal communication that promotes mental and psychosocial well-being;Meaningful activities which promote engagement and positive meaningful relationships;An environment and atmosphere that is conductive to mental and psychosocial well-being;Individualized, non-pharmacological approaches to care;Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, history of trauma and/or post-traumatic stress disorder, or other behavioral health condition Further review of policy states that the facility will have staff who provide services to residents with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and person-centered care plans. Review of facility assessment, completed on November 7, 2025, revealed that facility has 67 - 69 residents with behavioral health needs and 1 - 2 residents with active or current substance use disorder. Further review of facility assessment revealed that competency's related to ?caring for residents with mental and psychosocial disorders' are to be provided annually and as needed. Review of facility provided annual in-services and competencies revealed no evidence of training provided related to psychosocial needs, mental/behavioral health or substance use disorders for licensed practical nurses - Employees E17, E18, E19, E20, E21, E22, E23, E24,and E25. Interview with facility's staff educator, employee E26, on Thursday, April 16, 2026, at 1:00 pm, confirmed that facility has not been providing appropriate annual training based on facility assessment and Behavioral - Mental Health Care - Substance Use Services policy. 28 Pa Code 211.12 (d)(1)(2)(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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility meal test tray, review of resident council meeting minutes, resident interviews, and staff interview it was determined that the facility failed to provide foods that are palatable, attractive, and at appetizing temperatures.Findings Include: A meal test tray was completed on April 15, 2026. While in the kitchen trays of coffee cups were seen being prepared by a dietary staff at 12:45 p.m. The test tray left the kitchen at 1:18pm and went out to the B wing unit. The test tray was served at 1:24 p.m. The test tray contained a plate of baked ziti, broccoli, and garlic bread. The baked ziti was tasted and was not appetizing. The baked ziti was too overdone that is disintegrated without having to chew it. There were two beverages served, a milk and a coffee. The coffee temperature was 174.2 degrees. Interview with the Food Services Director Employee E7 revealed the coffee was poured directly out of the coffee urn. Typically, the coffee is poured into the cup, a lid put on, and it sits for 10 minutes. The Food Services Director Employee E7 was asked to provide point of service coffee temperature records. Employee E7 provided a Hot Beverage Temp log that states, pour at 7:10 a.m.-11:20 a.m. and 4:10 p.m. The record was completed for April 1, 2026 through April 15, 2026. Hot water and coffee temperatures were taken for breakfast, lunch, and dinner. For every temperature taken it has 140 degrees Fahrenheit written. Employee E7 was asked who takes the temperature for dinner service and he stated, my cook does. All signatures on the Hot Beverage Temp log appear to be the same. Hot Beverage Temp logs were requested for January, February, and March. Employee E7 was able to provide January and March. Employee E7 was only able to provide January and March. Breakfast, lunch, and dinner for January and March read 140 degrees Fahrenheit for all of the dates listed. A re-test of the coffee was made at 1:34 p.m. A cup of coffee was poured and a lid was placed on the cup at 1:34 p.m. The Food Services Director Employee E7 was then asked to test the temperature at 1:44 p.m. which would be ten minutes later. The temperature of the coffee in the cup was taken ten minutes after it was poured and it was 172.5 degrees Fahrenheit. The Food Services Director Employee E7 confirmed the above findings at 1:46 p.m. Review of Food Committee Meeting Minutes from February 24, 2026 states, burgers are cooked too hard food cannot be burnt. Further review of Food Committee Meeting Minutes from February 24, 2026 states, cold coffee on her tray-Coffee and hot water are both being temped in the kitchen before service. Coffee will not be sent on a tray with a temperature higher than 140 degrees Fahrenheit due to burn safety precautions. One rack of coffee or hot water at a time are being prepared. Review of Food Committee Meeting Minutes from Janauary 20, 2026 states, Resident R209-states he would like 2 sandwiches at lunch. Resident Council was held on April 16, 2026 at 11:00 a.m. Resident R209 was admitted to the facility July 4, 202. R209 had a MDS (Minimum Data Set) a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate the health, functional capabilities, and needs of residents completed on February 2, 2026 and Resident R209 had a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. Resident R209 states, the food here is horrible, it's so horrible I get two grilled cheese sandwiches everyday for lunch and dinner. Resident R165 was admitted to the facility on [DATE]. R165 had a MDS (Minimum Data Set) a standardized, federally mandated clinical assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate the health, functional capabilities, and needs of residents completed on February 13, 2026 and Resident R165 had a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. Resident R165 stated during resident council, the food her is always cold it can be hard to eat. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management28 Pa code 201.18 (b)(1) Management.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews with residents and staff, and review of the facility policy, it was determined that the facility failed to provide a clean, safe, comfortable and homelike environment in one of the five nursing units observed (C Wing).Findings Include: Review of facility policy titled, Resident Rights last revised April 6, 2026 states, Policy: Employees shall treat all residents with kindness, respect, and dignity. Procedure: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence b. Safe and home-like environment Interview held with Resident R114 on April 13, 2026 at 12:13 p.m. resident states that the facility has a problem with a hole in the bathroom on C-wing and it has not been fixed. A tour was taken of the C wing common bathrooms on April 14, 2026 at 10:03 a.m. The Tub Room was observed first and there was a hole in the wall behind door when you enter into the room. The second common bathroom was labeled Century Bath and had an Out of Order signed on the door. There was a hole behind the bottom base of the toilet. There was a hole in wall behind door. The bathroom had a sharps container that was overflowing with disposable razors. Employee E13 confirmed the above findings on April 14, 2026 at 10:06 a.m. During Resident Council Meeting held on April 15, 2026 at 11:00 a.m. revealed several residents stated that they did not currently have locked drawers. Resident R107 was admitted to the facility on [DATE]. Resident R107 stated that he has never had a lock for valuable items. Resident R107 stated that maintenance keeps saying that they ordered locks. Resident R107 also stated that the C-wing bath had a hole in the bottom of the shower until this week they fixed because you all are here, but there are still holes in the walls. The counter is not easy to access for me to shave my face. Resident R107 had a MDS (Minimum Data Set- assessment of resident's care needs) completed on April 8, 2026, and Resident R107 had a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On April 16, 2026, at 11:54 a.m. it was observed with the Director of Maintenance, Employee E12 two drawers with key locks but Resident R107 stated he did not have a key. There were also two drawers with pad locks. A pad lock was located on the handle of a bedside drawer but Resident R107 stated he did not have a key for it. Resident R107 stated that he has nice items in his larger linen closet and would like a lock and key for this area. Resident R107 was asked if he had one ever and he stated no I haven't. Interview held with Director of Maintenance Employee E12 on April 16, 2026, at 12:03 p.m. confirmed there are a whole bunch of keys unlabeled in the maintenance office I just have not had the time to go through yet to see what is what. Interview held with the Regional Director of Maintenance Employee E13 on April 16, 2025 at 12:11 p.m. Employee E13 was asked who was in charge of asking the resident if they would like a locked drawer at the time of admission Employee E13 stated, It is nursing and admissions. After they know they want one they put it into TELS (their electronic system) and we will handle it right away. Interview held with the Director of Admissions Employee E6 on April 16, 2025, at 1:31 p.m. Employee E6 was asked if a part of the admissions process there is a current form regarding offering residents a locked drawer? Employee E6 stated yes there is. When asked if Employee E6 was currently completing them at the time of admission and having the resident sign off she stated, no, it's maintenance that asks and makes sure to provide the resident with a locked drawer. Resident R114 was admitted to the facility on [DATE]. 2025. Resident R1114 had a MDS completed on April 3, 2026, and Resident R114 had a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. Resident R114 stated that she has not been given a lock for her any drawer and she would like one. When asked if she was ever offered one she stated, no. Resident R18 was admitted to the facility on [DATE]. Resident R18 had a MDS completed on March 9, 2026, and Resident R18 had a BIMS score of 15 indicating no cognitive impairment. Resident R18 stated, I was never given a locked drawer or offered one. 28 Pa. Code 201.18 (b)(1) Management

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident's clinical records, facility documentation and staff interviews, it was determined that the facility failed to ensure that one of one residents were free from verbal abuse (Resident R246).Findings include: Review of facility policy Abuse Policy-Prevention and Management revised September 8, 2022, revealed verbal abuse includes, but is not limited to oral, written, or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient or their families, or within their hearing distance, to describe resident/patient, regardless of their age, ability to comprehend or disability. The policy continues by saying Examples of verbal abuse include, but are not limited to:Harassing a resident;Mocking, insulting, ridiculing;Yelling or hovering over a resident, with the intent to intimidate;Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; andIsolating a resident from social interaction or activities.The policy states any mistreatment, neglect and abuse of residents/patients.by anyone including staff, family, visitors, etc. is prohibited and the facility is responsible for providing a safe resident environment and protecting residents from abuse. Review of Resident R246's clinical record revealed that Resident R246 was initially admitted to the facility on [DATE], and then readmitted from the hospital on March 5, 2026. Further review of Resident R246's clinical record revealed the diagnoses of included muscle wasting and atrophy (decrease in size of body tissue, organs or muscle), Urinary tract infection (UTI), hydronephrosis (swelling of kidney due to urine retention, caused by an obstruction or blockage in urinary tract), other artificial openings of urinary tract status (nephrostomy tube of right kidney), chronic kidney disease Stage 4 (CKD, severe), and personal history of other malignant neoplasm of kidney (kidney cancer). Review of Resident R246's clinical records reveal she had a BIMS (Brief Interview for Mental Status, a screening tool used in Long Term Care to assess cognitive function) revealed Resident R246 had a score of 15, indicating resident had no cognitive impairment (cognitively intact). Review of Resident R246's written statement revealed that during care on the commode, nurse aides Employees E31 and E32 were assisting resident, when Employee E31 pulled Resident R246's pants down forcefully, causing her to cry out for Employee E31 to be careful, as she did not want her to pull on her right-sided nephrostomy tube. However, per Resident R246's account, the force of the pulling did pull on the nephrostomy tube and caused bleeding. She then called the supervisor, Employee E30, who came to speak to the resident; the nurse aide Employee E31 tried to talk over the resident, the supervisor dismissed the nurse aide from the room and as she exited she stated That's why no one wants to work on this floor and said resident was causing trouble. The resident admitted ly replied to the aide if she didn't like her job, to find another one. Review of written statement and documentation from the supervisor, Employee E30, revealed he was called to Resident R246's room by the charge nurse, Employee E33, to come speak with Resident R246. After speaking to the resident, who told him the above narrative and added that the nurse aide stated the resident was abusing the CNAs (nurse aides) and would not allow Resident R246 to abuse her, the supervisor asked nurse aide Employee E31 if she made these statements, and Employee E31 confirmed she had. He told the aide this was not the way to speak to residents, and the nurse aide said it's the truth. He then told her to leave. The supervisor stated the behavior of the aide was disrespectful and rude. This supervisor was unavailable for interview. Review of Nurse aide, Employee E32 written statement who was assisting Employee E31, confirmed the exchange between Employee E31 and Resident R246 (which she witnessed), and added that Employee E31 stated to the resident I'm not on your tube, let me do my job unless you want someone else to come do it. Review of written statement and documentation by the Charge nurse, Employee E33, revealed the nurse aide Employee E31 admitted to the charge nurse what she said to Resident R246, and the charge nurse added that the nurse aide continued arguing with Resident R246 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the hallway, calling her a liar and accusing resident of abusing staff, then the aide stated she did not need to deal with this and left the floor, stating that she was leaving. Review of the incident report made by the Director of Nursing, Employee E2, to the Pennsylvania Department of Health on March 2, 2026 , revealed the nurse aide Employee E31 had been suspended pending the investigation (from March 3 to March 5), and terminated after conclusion of the investigation for rude, disrespectful behavior towards a resident during care. The allegation of verbal abuse by nurse aide, Employee E31 of resident R246 was substantiated. Resident R246, was unavailable for interview, as the resident was discharge from the facility on March 6, 2026. Interview with Assistant Director of Nursing, Employee E3, at 1:35 PM on April 16, 2026, confirmed the substantiated allegations of verbal abuse and the termination of Employee E31. Interview with the Unit Manager for E Unit, Employee E23, at approximately 1:00 PM on April 16, 2026, who documented on the nursing assessment of the nephrostomy tube at 16:00 the day following the incident (March 3), revealed she had spoken with the resident about the incident and confirmed verbal abuse by nurse aide Employee E31. She additionally confirmed that the nurse aide involved (Employee E31) had been terminated. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.29(j) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a baseline care plan that included the minimum information necessary to properly care for a resident related to urinary catheter within 48 hours of admission for one of one resident reviewed. (Resident R232)Findings include: Facility policy titled Care Planning Process and Care Conference, revised on March 19, 2025, indicates that An interdisciplinary baseline care plan will be initiated upon admission by the admitting nurse and completed within 48 hours. The policy further indicates that this is Care Plan is to include such initial needs/problems such as ADL's, falls, skin tears, risk for skin breakdown, nutritional status, behaviors, pacemaker, anticoagulants, psychotropic medication use etc. Include a care plan related to the resident's primary diagnosis. Review of Resident R232's clinical record revealed Resident R232 was originally admitted to the facility on [DATE] and then readmitted on [DATE] after a hospital stay. The resident was readmitted to the faciltiy with an indwelling urinary catheter. The resident's diagnoses include to benign prostatic hyperplasia or BPH (enlarged prostate), presence of urogenital implants (penile implant), Alzheimer's Disease (a type of Dementia, cognitive impairment) and Dementia, urinary tract infection and retention of urine. Review of Resident R232's care plan dated April 9, 2026 revealed to monitor new foley for amount/ color and odor. There were no interventions related to the care of the indwelling foley catheter such as instructions for replacement/indications of need for other replacement or when to seek medical attention. R Interview on April 16, 2026, at 1:52 PM with Employee E27, Licensed Practical Nurse (LPN) revealed the absence of a Care Plan for the foley catheter for Resident R232. 28 Pa. Code 211.10(d) Resident care policies

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of policy, review of clinical records and review of facility provided documentation, it was determined facility did not ensure to develop and implement a resident centered care plan for one of 36 residents reviewed related to substance use disorder. (Resident R245)Findings include:Review of facility policy ?Care Planning Process and Care Conference,' revised on March 19, 2025, indicated that to foster the philosophy of the facility, in compliance with Federal and State Regulations and in accordance with HIPPA Regulations, the facility will develop a comprehensive, resident centered care plan for each resident/patient. Care plan development, renewal and revision will be based upon the results of the resident assessment. Review of facility policy ?Behavioral - Mental Health Care - Substance Use Services,' revised March 19, 2025, states that Individualized Assessment and Person-Centered Planning includes assessing psychosocial well-being , mood state, and behavioral symptoms by the interdisciplinary team (IDT). Further review of policy revealed that facility must assess the resident who had an overdose for their history of substance use and risk for using substances while in the facility, which could lead to an overdose in the facility. Relapse of substance use can be common in residents with SUD and may result in overdose.The comprehensive care plan should contain interventions, if appropriate, to prevent substance use in the facility as well as interventions for when substance use is suspected or identified.Care plan interventions should include increased monitoring and supervision, increased supervision of visitors, and notification of the physician and/or practitioner. Review of psychosocial evaluation/supportive care, completed on March 18, 2024, at 10:43 am, revealed that Resident R245 has a history if substance abuse and risks associated with drug abuse and accidental overdosing and triggers were discussed. Further review of psychosocial evaluation revealed that Resident R245 had a mental disorder, psychosocial adjustment difficulty, had a history of serious accident, was physically threatened - including situations that were extremely frightening, as well as witnessed extremely frightening situations. Review of Resident R245 past medical history revealed diagnosis of chronic pain syndrome, anxiety, severe sepsis with septic shock, alcohol abuse, major depressive disorder, other psychoactive substance dependance, schizophrenia. Review of Resident R245 clinical record revealed that on December 2, 2025 Resident R245 was transferred to hospital and tested positive for amphetamines, barbiturates, methadone, opiates, and phencyclidine. Review of Resident R245 care plan revealed no evidence of coping skills or relapse prevention strategies for drug abuse were developed. 28 Pa Code 211.12(d)(5) Nursing services 28 Pa Code 211.10(c)(d) Resident care policies

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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 review of facility policy, clinical record, facility documentation, and interview with staff, it was determined the facility did not ensure adequate supervision for one resident with a history of substance use disorder (SUD). (Resident R245). Findings include: Review of facility policy ?Behavioral - Mental Health Care - Substance Use Services,' revised March 19, 2025, states that behavioral health encompasses a resident's whole emotional and mental well-being which includes, but not limited to the prevention and treatment of mental health disorders, and SUD. Residents demonstrating change/s in behavior shall be evaluated to ensure that appropriate interventions, (both non-pharmacological and pharmacological) as needed, are instituted in a timely manner. Further review of policy identifies substance use disorder as a recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school or home. Residents with SUD may try to continue using substances during their stay. Staff should assess the resident for risk for use in the facility and have knowledge of signs and symptoms of possible substance use. Steps the facility may take if substance use is suspected: Increase monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents;Monitoring for symptoms such as but not limited to feeling of exhilaration, increased alertness, increased energy and restlessness, frequent leaves of absence with or without staff knowledge, behavior changes or aggression, mood changes, particularly after interaction with visitors or absence from the facility , rapid or rambling speech, dilated pupils, irritability, anxiety, unresponsiveness, inability to communicate or follow commands, decreased respiratory rate, pinpoint pupils if overdose is suspected;Facility efforts to help residents such as individual counseling services, access to group counseling, 12 step program, support groups or access to a medication assisted treatment (MAT) program, if applicable;Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff. Review of facility policy ?Visitation, Non-Pandemic/Epidemic conditions,' revised August 19, 2025, under ?Visitation and illegal substance use,' revealed that it is important for facility staff to have knowledge of signs, symptoms, and triggers of possible illegal substance use; such as changes in resident behavior, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. This may include asking residents, who appear to have used an illegal substance (e.g., cocaine, hallucinogens, heroin), whether or not they possess or have used an illegal substance. Further review of policy revealed that if the facility determines through observation that a resident may have access to illegal substances that they have brought into the facility or secured from an outside source, the facility should not act as an arm of law enforcement. To protect health and safety of residents, facility may need to provide additional monitoring and supervision. Review of Resident R245's clinical record revealed he was initially admitted to facility on March 2, 2020 for back pain with past medical history of intravenous drug abuse involving heroin, hepatitis C, PSH of plates in head from trauma (Paroxysmal Sympathetic Hyperactivity is a syndrome of autonomic nervous system dysfunction-characterized by fever, hypertension, and tachycardia-often occurring after traumatic brain injury (TBI), anxiety. Review of facility provided investigation report, completed on December 3, 2025, at 12:04 pm, revealed that Resident R245 alert and oriented to person, place and time, and had a brief interview for mental status (BIMS) score of 15. Resident R245 was also able to ambulate with a rolling walker. Review of Resident R245's clinical record revealed a physician note dated 11/26/2025, stating that Nurses note that while he (Resident R245) often is fine, he has periods of being out of it or agitated, especially after leave of absence (LOA). Further review of investigation report revealed that on Sunday, 11/30/25, at approximately 11:20 pm, [Resident R245's] roommate (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came to the desk and stated that the resident was in the bathroom for a long time. Nursing staff went to the room and observed the resident on the toilet and having some tremors. He was able to respond to his name. His vital signs were stable. Nursing staff attempted to assist resident off the toilet and he became aggressive with them. Resident R245 then calmed down and allowed them to assist him off the toilet. Staff questioned the resident if he took anything because this behavior is not (his/her) norm. The resident stated ?no.' The MD (physician) was called and orders were received to send the resident to the hospital, however the resident refused to go to the hospital. [Resident R245] had a visit from his wife on 11/28/25, and according to his room mate he gave her money and she left. The roommate could not report if she gave (him/her) anything. [Resident R245's] wife did visit him occasionally and they would go out to eat. There were no alterations in his behaviors after these visits. On 12/2/25 [Resident R245] had a temperature of 100F (Fahrenheit), heart rate of 48 ([NAME] heart rate is 60-100). [Resident R245] agreed to go to the hospital. 911 (Emergency Medical Services) was called and the resident was sent to ER (Emergency Room) at approximately 03:22 am. A drug screen was done and the hospital notified facility it was positive for amphetamines, barbiturates, methadone, opiates, and phencyclidine. Further review of progress notes revealed clinical nurses note, dated 12/1/2025, at 01:12 am, stating that Resident R245 was found urinating on himself, shaking uncontrollably not related to seizure activity, in and out of coherence but alert when staff attempted to assist resident with changing and back to bed. Resident lashed out swinging violently and pushing staff away. He was escorted to bed, MD notified and received call back at approximately 6:00 am with a new order to send [Resident R245] to hospital for evaluation. However, [Resident R245] continued to refuse to be sent out for evaluation. Further review of clinical nurses note, dated 12/1/2025, at 3:50 pm, revealed that unit manager was notified that Sunday into Monday resident was observed combative and aggressive toward staff - resident wife is believed to have given him a substance, resident noted with tremors but per RN (Registered Nurse) the vitals were within normal limits, and is ambulating to and from bathroom. Nurse attempted to assist [Resident R245] from bathroom to bed but (he/she) again became combative, yelling . continued to refuse to be sent to ER for evaluation. MD gave new orders to discuss that wife must visit resident going forward in supervised area and supervised visits need to be scheduled, Review of physician orders revealed that a verbal order was given by MD, Employee E14, on December 1, 2025, at 9:00 am for supervised visits. Interview with Licensed nurse, Employee E15, on 4/15/2026, at 11:00 am, confirmed that she received a verbal order at 9:00 am on December 1, 2025, for Resident R245 to have supervised visits; Employee E15 also confirmed that on December 1, 2025, Resident R245 had an unsupervised visit from wife, from 2:35 pm to 3:40 pm. Further review of facility provided investigation report revealed that on either Thursday or Friday (11/27/25 or 11/28/25) Resident R245's wife came for his car but he wasn't allowed to go out on the leave. That night Resident R245 slept the entire night. Throughout the weekend he was mumbling but would say he wasn't. Resident R245 was in the bathroom off and on for long intervals. He was walking to the bathroom by himself. Resident R245 was asked what he took but he wouldn't tell. Resident R245 mentioned being stressed because his wife was smoking crack again. Facility failed to supervise and monitor a resident with extensive history of drug abuse and mental/behavioral health disorders. 28 Pa Code 211.12(d)(1)(5) Nursing services28 Pa Code 211.10(a)(c) Resident care policies