STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based clinical record review and interview with staff, it was determined the facility failed to provide the right to communication with and access to persons and services outside the facility for one resident out of 20 sampled (Resident 51). Findings Include: A clinical record review revealed Resident 51 was admitted to the facility on [DATE], with diagnosis to include a hereditary ataxia (a group of genetic disorders characterized by progressive problems with coordination and balance (ataxia) that are inherited from one generation to the next. These conditions affect the nervous system, particularly the parts of the brain responsible for motor control, such as the cerebellum, spinal cord, and peripheral nerves) and muscle weakness. A review of the quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 14, 2025, revealed the resident was moderately cognitively impaired with a BIMS score of 12 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8-12 indicates moderate cognitive impairment). A review of a letter from the Pennsylvania Department of Human Services dated May 9, 2025, regarding Resident 51's request for a fair hearing appeal from a decision made by the Office of Income Maintenance, revealed that a telephone hearing with an Administrative Law Judge was scheduled for May 28, 2025, between 9:00 AM and 12:00 PM. The letter stated the Judge would place the call during that window and that if the resident was not available, the case could be dismissed. It further stated that if the resident or a representative was unavailable and failed to provide a valid reason before the hearing, the hearing would not be postponed, and the appeal would be denied. A postage-paid acknowledgement card was enclosed to confirm attendance. Review of the acknowledgement card dated May 9, 2025, revealed confirmation the resident would be present on May 28, 2025, at 9:00 AM for the telephone hearing. The acknowledgement form was signed by Employee 2 (former Business Office Manager) on May 19, 2025. Review of a letter from the PA Department of Human Services dated May 29, 2025, revealed Resident 51 did not attend nor provide good cause for not being available for the hearing scheduled for May 28, 2025, at 9:00 AM. As a result, Resident 51's appeal was dismissed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator (NHA) on June 12, 2025, at 9:45 AM confirmed the facility failed to ensure Resident 51 had access to services outside the facility. The NHA stated that Employee 2 resigned abruptly on May 21, 2025, and failed to inform other facility staff that Resident 51 had a scheduled hearing on May 28, 2025. The NHA further stated that the Regional Business Office Manager was attempting to appeal the dismissal and reschedule the hearing on behalf of the resident. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and interviews with residents and staff, it was determined the facility failed to conduct care plan conferences and failed to ensure that residents were invited to participate in the care planning process for three of 20 residents reviewed (Residents 16, 51, and 85). Findings include: Review of the facility Care Planning- Interdisciplinary Team Policy last reviewed May 1, 2025, indicated the interdisciplinary team (IDT) is responsible for resident care plans. The IDT includes but is not limited to the resident's attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of the food and nutrition staff, to the extent practicable the resident and/or the resident's representative, and other staff as necessary to meet the needs of the resident, or as requested by the resident. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. If it is determined that participation of the resident or representative is not practicable for the development of the care plan, an explanation is documented in the medical record. Social services director, therapy (if on case load), nursing, and activities are to attend meetings. During an interview conducted on June 10, 2025, at 10:30 AM, Resident 16 stated that he had not been invited to participate in the care planning process and had not attended any care plan meetings with facility staff. He expressed interest in meeting with staff to discuss his care. A review of the clinical record revealed that Resident 16 was admitted to the facility on [DATE], transferred to the hospital on December 27, 2024, and readmitted on [DATE]. He was hospitalized again on January 31, 2025, and subsequently readmitted to the facility on [DATE], with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe) and Parkinson's disease (a movement disorder of the nervous system that worsens over time). Review of Resident 16's admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 13, 2025, revealed the resident 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 13-15 indicates cognitively intact). Review of the clinical record revealed no documented evidence that a care plan meeting had been conducted for Resident 16 following the February 13, 2025, admission MDS or that the resident had been invited to participate in the development or review of his comprehensive care plan. Review of Resident 16's quarterly MDS dated [DATE], revealed the resident remained cognitively intact with a BIMS score of 15. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plan Report dated April 29, 2025, indicated that a care plan meeting was held between the resident and the facility's social worker. A corresponding social services progress note, also dated April 29, 2025, documented that the resident's code status, Resident Representative/POA (power of attorney), weight, oxygen use, blood pressure, discharge from therapy, and wounds were reviewed during this meeting. The note indicated that the resident would remain in the facility for long-term care and that assistance would be provided as needed. However, there was no documented evidence that required members of the interdisciplinary team (IDT), including representatives from nursing and activities, participated in the April 29, 2025, care plan meeting, as outlined in the facility's Care Planning policy. During an interview conducted with the Nursing Home Administrator (NHA) on June 12, 2025, at approximately 12:40 PM, the NHA was unable to provide documentation confirming that a care plan conference with IDT members was held following Resident 16's February 13, 2025, admission MDS or the April 21, 2025, quarterly MDS. There was no evidence that the resident's comprehensive care plan was reviewed by the full IDT to ensure development and discussion of the resident's goals, needs, and preferences in all areas of care. A clinical record review revealed Resident 85's was admitted to the facility on [DATE], with diagnoses to include spinal cord compression (pressure on the spinal cord causing numbness, pain, weakness and loss of bowel and bladder control), muscle weakness, and need for assistance with personal care. A review of the quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 14, 2025, revealed the resident 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 13-15 indicates the resident is cognitively intact). During an interview on June 10, 2025, at 2:00 PM, Resident 85 stated that she had not been invited to participate in the care planning process or any care plan meeting since admission. A review of the clinical record revealed no documentation of a care plan conference or invitation to participate in the development or review of her comprehensive person-centered care plan. A clinical record review revealed Resident 51 was admitted to the facility on [DATE], with diagnosis to include a hereditary ataxia (a group of genetic disorders characterized by progressive problems with coordination and balance (ataxia) that are inherited from one generation to the next. These conditions affect the nervous system, particularly the parts of the brain responsible for motor control, such as the cerebellum, spinal cord, and peripheral nerves) and muscle weakness. A review of the quarterly MDS dated [DATE], revealed that Resident 51 was moderately cognitively impaired with a BIMS score of 12 (a score of 8-12 indicates moderate cognitive impairment). Review of the clinical record revealed no documented evidence that a care plan conference had been conducted for Resident 51 or that the resident and resident's Responsible Party had been invited to participate in the development or review of his comprehensive care plan. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nursing Home Administrator (NHA) on June 12, 2025, at 11:30 AM, the NHA confirmed there was no documentation to show that a care plan conference had been held for Resident 85 or 51 or that the resident and/or Responsible Party had been invited to participate in the care planning process. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12(d)(3) Nursing services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and staff interviews, it was determined that the facility failed to provide prescriptions for physician-ordered medications at the time of discharge to ensure a safe and orderly transition to home for one resident out of four closed records reviewed (Resident 146). Findings include: Review of the facility Discharge Summary and Plan Policy last reviewed May 1, 2025, indicated that when a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's current diagnosis, medical history, course of illness, treatment and/or therapy since entering the facility, and medication therapy (all prescriptions and over-the-counter medication taken by the resident including dosage, frequency of administration, and recognition of side effects that would be most likely to occur in the resident). Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes arrangements that have been made for follow-up care and services, the degree of caregiver/support person availability, capacity and capability to perform required care, and how the IDT (interdisciplinary team- group of healthcare professionals from various disciplines who work together to provide comprehensive and coordinated care for residents) will support the resident or representative in the transition to post-discharge care. A member of the IDT reviews the final post-discharge plan with the resident and family at least twenty-four hours before the discharge is to take place. Review of the clinical record revealed that Resident 146 was admitted to the facility on [DATE], with diagnosis to include paraplegia (paralysis of the legs and lower body). The resident was discharged from the facility to home on May 12, 2025. Review of the Discharge Plan of Care dated May 8, 2025, indicated that the resident was scheduled to discharge on [DATE]; a follow-up appointment was scheduled with the primary care provider for May 19, 2025; home health services were arranged; and written prescriptions were to be provided to the resident or resident representative. A nurse's note dated May 12, 2025, documented that the resident was discharged to home with transportation via family. The resident was alert to person, place, and time at discharge. Discharge instructions were reviewed with the resident, and belongings and medications were sent with the resident. However, a facility Follow-Up Discharge Call note dated May 13, 2025, documented that the resident needed prescriptions for medications. Further review of the clinical record revealed no documented evidence that the facility followed up on the identified concern that the resident had not received prescriptions at the time of discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An email dated May 16, 2025, from the home health agency to the facility documented the resident had not been discharged with an adequate supply of medication to last until her scheduled follow-up appointment with her primary provider on May 19, 2025. The email requested instructions for obtaining the necessary prescriptions. During an interview with the Assistant Director of Nursing (ADON) on June 13, 2025, at 10:40 AM, the ADON stated she was made aware on May 16, 2025 (three days after the facility was made aware that the resident did not have prescriptions), the resident required prescriptions. She contacted the resident's community physician to review the discharge medication list so that prescriptions could be provided. The ADON confirmed the resident did not receive enough medications upon discharge to last until the follow-up appointment with the physician on May 19, 2025. During an interview with the Nursing Home Administrator on June 13, 2025, at approximately 11:00 AM, the administrator confirmed that the Discharge Summary incorrectly indicated that prescriptions were provided. The administrator confirmed that prescriptions should have been given to the resident at the time of discharge and acknowledged this did not occur. 28 Pa. Code: 201.29 (a) Resident rights. 28 Pa. Code 211.5 (d) Medical Records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 20 sampled (Resident 19). Findings included: A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from disease of the brain). A review of Resident 19's quarterly MDS assessment dated [DATE], revealed in Section P0100, Physical Restraints, Resident 19 required a limb restraint used in chair or out of bed documented as Code 1 indicating the device was used less than daily. A review of physician's orders for Resident 19 failed to identify any orders for the resident to have a physical restraint. An interview with the Regional Nurse Consultant on June 11, 2025, at approximately 11:00 AM confirmed the resident has never had any type of physical restraint while residing in the facility. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to follow the comprehensive care plan by not ensuring the consistent application of preventative measures for fall safety for one of 20 residents sampled (Resident 50). Findings include: A review of the facility policy titled Falls-Clinical Protocol, last reviewed by the facility on May 1, 2025, revealed that based on the fall assessment for the resident, the staff and physician will identify pertinent interventions to try to prevent subsequent falls to address risks of serious consequences of falling. A review of the clinical record revealed Resident 50 was admitted to the facility on [DATE], with diagnoses to include liver cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue) 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 quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 50, dated April 11, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 05 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). Review of the resident's comprehensive care plan, in effect through the survey end date of June 13, 2025, revealed the resident was at risk for falls, had a history of falls with the most recent documented on April 2, 2025, and had planned fall prevention interventions in place. These included the use of a bolster (a long pillow or cushion used for support) to the right side of the bed and a beveled fall mat to the left side of the bed. A fall risk evaluation dated April 3, 2025, confirmed that Resident 50 was identified as being at high risk for falls. Observation of Resident 50 in his room on June 12, 2025, at 1:45 PM revealed the resident lying in bed. At the time of the observation, there was no bolster present to the right side of the bed and no beveled fall mat present to the left side of the bed, as required by the resident's care plan. This was confirmed by Employee 1, Licensed Practical Nurse. An interview with the Nursing Home Administrator on June 12, 2025, at approximately 2:00 PM confirmed that staff had not consistently followed the comprehensive centered care plan for application of a bolster to the right side of the bed and a beveled fall mat to the left side of the bed for safety for Resident 50. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation and select facility policies and procedures and staff interview, it was determined that the facility failed to provide nursing services, which met professional standards of quality according to Title 49, Professional and Vocational Standards Chapter 21 State Board of Nursing during medication transcription and medication administration resulting in a medication error for one of 22 residents reviewed. (Resident 3)Findings include: According to Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all the following functions: (4) Carries out nursing care actions which promote, maintain and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.14. (a) A licensed registered nurse may administer a drug ordered for a patient in the dosage and manner prescribed. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place and (b) the LPN administers medication and carries out the therapeutic treatment ordered for the patient. A review of the facility policy and procedures for, Medication Administration, no revision date available at the time of the survey, revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications. A review of the clinical record revealed that Resident 3 was admitted to the facility on [DATE] with diagnosis to include, cancer of the rectum and lung and atrial fibrillation (a rapid, irregular, heartbeat).An admission MDS dated [DATE] revealed the resident to be cognitively intact (BIMS of 15, a score of 13 to 15 indicates cognitively intact). Nursing documentation revealed Resident 3 was hospitalized on [DATE], and readmitted on [DATE]. A physician's order dated June 13, 2025, directed administration of Eliquis (apixaban, an anticoagulant or blood thinner) 5 mg by mouth twice daily. This order was not discontinued, and the medication was not removed from the medication cart when the resident was discharged to the hospital on June 27, 2025. Upon readmission on [DATE], the admission physician's orders included apixaban 2.5 mg (Eliquis, a blood thinning medication) by mouth every morning and evening for anticoagulation. Employee 2 (RN) completed both the discharge process on June 27, 2025, and the admission process on July 3, 2025, including transcription of the admission orders. The original 5 mg apixaban order remained active on the July 2025 MAR (medication administration record). Employee 3 (RN) failed to ensure that the resident's physicians orders were correct to prevent a potential medication error. On July 3, 2025, at 9:00 AM, the MAR documented that Employee 1 (agency LPN) administered both apixaban 5 mg and apixaban 2.5 mg for a total of 7.5 mg. This constituted a significant medication error by exceeding the prescribed anticoagulant dos resulting in a medication error. A facility Medication Error report dated July 4, 2025, confirmed that the previous apixaban 5 mg order had not been discontinued upon hospital discharge and the medication remained in the medication cart. The report also noted the absence of employee witness statements. During an interview with the Director of Nursing (DON) on July 29, 2025, at approximately 1:00 PM, the DON confirmed she did not obtain witness statements at the time of the incident. She further stated that Employee 2 (RN) was disciplined following the incident, and Employee 1 (LPN) remained employed but had not completed any medication administration competencies because of the error. The DON acknowledged that professional nursing standards were not followed to prevent a medication error. 28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and resident and staff interviews, it was determined that the facility failed to ensure one resident dependent on staff for assistance with activities of daily living (ADLs) consistently received showers as planned to maintain personal hygiene for one of 20 sampled residents (Resident 85). Findings include: A review of Resident 85's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include spinal cord compression (pressure on the spinal cord causing numbness, pain, weakness and loss of bowel and bladder control), muscle weakness, and need for assistance with personal care. A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 14, 2025, indicated the resident required substantial/maximal assistance from staff for showering/bathing. The resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates the resident is cognitively intact). During an interview with Resident 85 on June 10, 2025, at 2:00 PM, she reported that staff are not consistent with providing her a shower on her scheduled shower days. She stated, Tuesday and Saturdays are my shower days. This morning (Tuesday), I missed my shower because staff got me up late and I had to go to therapy. I asked for a shower after I came back from therapy and the aide told me she won't have time. It's not my fault she got me up late. I asked to be up by 9:00 AM and she got me up at 10:30 AM. She continued, they marked me down as refusing a shower but I'm not refusing, I just don't want to miss therapy. She stated this situation happened recently on a Saturday while her son was visiting. She stated she told staff her young son was visiting at 10:00 AM and that she needed to up be early. Staff did not get her up early enough to bathe her. During the visit with her son, staff interrupted the visit and asked if she wanted her shower. She stated she declined the shower at that moment because she needed to spend time with her son. Staff did not return to offer the shower after her son left the facility, which was around 11:00 AM. A review of the resident's electronic Kardex (a quick-reference summary for staff to guide delivery of care) documented that Resident 85 was scheduled to receive showers on Tuesdays and Saturdays during the day shift. Review of the April 2025 shower logs for Resident 85 revealed that she did not receive a shower during the entire month. Bed baths were documented instead on Saturday, April 12; Tuesday, April 15; Saturday, April 19; Tuesday, April 22; Saturday, April 26; and Tuesday, April 29, 2025. There was no documentation to indicate that the resident refused a shower or had requested a bed bath in lieu of a shower. (continued on next page)

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	395298	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Similarly, a review of the May 2025 shower logs revealed that the resident did not receive showers on Saturday, May 3, and Tuesday, May 13, 2025. Bed baths were documented on Tuesday, May 6; Saturday, May 10; and Saturday, May 17, 2025. Again, there was no documentation to reflect that the resident refused a shower or had expressed a preference for bed baths. There was no documented evidence that the facility provided showers to the resident two times per week as scheduled and no documentation to explain why showers were omitted. During an interview conducted with the Nursing Home Administrator (NHA) on June 12, 2025, at approximately 1:00 PM, the NHA confirmed that Resident 85 was scheduled to receive showers on Tuesdays and Saturdays and acknowledged that showers should have been provided as scheduled. The NHA was unable to explain why showers were not consistently provided. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of 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 20 residents sampled (Resident 8). Findings include: Review of the facility Restorative Nursing Services Policy, last reviewed May 1, 2025, revealed that residents will receive restorative nursing care as needed to help promote optimal safety and independence. Further review of the policy revealed that the resident's restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. A review of the clinical record for Resident 8 revealed the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and generalized muscle weakness. A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 8, dated April 24, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 07 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment) and that the resident required substantial/maximal assistance for ambulation. Review of the clinical record indicated that physical therapy services were provided to Resident 8 from April 18, 2025, through May 9, 2025. Review of the resident's physical therapy Discharge summary dated [DATE], indicated at the time of discharge the resident could ambulate 150 feet with the assistance of one person with a front-wheeled walker. The prognosis to maintain the current level of functioning was described as excellent with participation in RNP (Restorative Nursing Program). Discharge recommendations included an assistance device for safe functional mobility, assistance with activities of daily living, and RNP/FMP (Functional Maintenance Program). RNP/FMP recommendations were to facilitate the resident maintaining their current level of performance and to prevent decline, and that development and instruction in the following RNPs had been completed with the IDT (Interdisciplinary Team) for ambulation of 150 feet with front-wheeled walker with the assistance of one to increase functional mobility. A review of the resident's care plan in effect through the survey end date of June 13, 2025, identified that the resident had an ADL self-care performance deficit related to generalized weakness and required extensive assistance. However, there was no documented evidence that the RNP for ambulation had been incorporated into the care plan, despite being recommended at discharge from therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 8's electronic task report (a summary of scheduled and completed resident-centered care tasks) and the Documentation Survey Report v2 for the months of May and June 2025 revealed no documented evidence that the restorative ambulation program had been implemented. Additionally, there was no documentation indicating that licensed staff were aware the resident's ambulation program was not being implemented as planned to ensure the resident's ambulation goal was met to the extent possible. An interview with the Assistant Director of Nursing (ADON) on June 13, 2025, at approximately 11:30 AM, confirmed the facility failed to consistently implement the planned restorative nursing program for Resident 8 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 211.12(c)(d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician's orders for one resident out of 20 sampled (Resident 16). Findings include: A review of the facility Oxygen Administration Policy last reviewed May 1, 2025, revealed the purpose of the facility policy is to provide guidelines for safe oxygen administration. The policy indicates to verify there is a physician's order for oxygen administration and document the rate of oxygen flow, route, and rationale. A clinical record review revealed that Resident 16 was admitted to the facility on [DATE], with diagnosis to include respiratory failure (serious condition that makes it difficult to breathe). A physician order dated May 7, 2025, noted an order for oxygen 4 liters/minute via nasal cannula every shift for a diagnosis of COPD (chronic obstructive pulmonary disease- a group of lung diseases that cause airflow obstruction and breathing problems). An observation on June 10, 2025, at 11:25 AM revealed the resident was sitting upright in bed with supplemental oxygen in place via nasal cannula with the liter flow set at 3.0 liters/minute on the oxygen concentrator. An observation on June 11, 2025, at 12:45 PM revealed the resident was sitting in his wheelchair with supplemental oxygen in place via nasal cannula with the liter flow set at 3.0 liters/minute on the oxygen concentrator. Interview with employee 3 (LPN) during the observation confirmed that the resident's oxygen liter flow was set at 3 liters/minute not at 4 liters as prescribed. During an interview on June 11, 2025, at approximately 1:00 PM, the Corporate Regional Nurse confirmed it is the facility's responsibility to ensure oxygen therapy is administered per physician's 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to implement procedures to ensure the timely acquisition and administration of prescribed medications for three of 20 sampled residents (Residents 49, 78, and 82). Findings include: A review of facility policy labeled Medication Process- Medications Unavailable last reviewed May 1, 2025, revealed the Licensed nurse is to check the Med Cubex (a pharmacy inventory management system) Inventory on Hand first. If a medication is identified as not being available in the Cubex, the Licensed nurse is to call the pharmacy to determine the medication deliver status. Following the information received from the pharmacy, the licensed nurse is to call the physician with the information on the medication delivery status and request a new order for medication administration if the medication will not be available to be administered. An interview with the Director of Nursing (DON) and the clinical nurse consultant on June 12, 2025, at approximately 11:32 AM revealed that to obtain a controlled medication (a medication with potential for abuse), a licensed nurse must contact the pharmacy to receive a code to retrieve the medication from the Med Cubex. A review of Resident 49's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Dementia (the loss of cognitive functioning that affects a person's ability to perform everyday activities). A review of physician's orders dated May 16, 2025, revealed the physician prescribed Xanax 0.25 mg (medication used to treat anxiety) one tablet by mouth every eight hours for anxiety beginning on May 16, 2025. A review of the May 2025 medication administration record (MAR) showed that the Xanax was not administered on May 27 at 10:00 PM, May 28 at 6:00 AM and 2:00 PM. The MAR was coded 9 to indicate see nurses' notes. A nursing progress note dated May 27, 2025, at 9:36 PM documented the dose was not given because the nurse was waiting on pharmacy, med unavailable. Additional record review indicated the medication had not been received because a new prescription was required. A nursing progress note dated May 28,2025 at 5:05 AM indicated the morning dose of Xanax was not given because the medication was unavailable. Further record review revealed the facility had not received the Xanax from the pharmacy because Resident 49 needed a new prescription. Continued review of the record revealed a nursing progress note dated for May 28, 2025, at 1:01 PM revealed the medication was unable to be pulled from the Cubex and was awaiting a return call from the physician. Further review of the MAR revealed no signature on May 29,2025, at 6:00 AM to indicate the medication was administered at the ordered time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review of Resident 78 revealed they were admitted to the facility on [DATE], with diagnoses to include atrial fibrillation (a condition that causes the heart to beat irregularly, sometimes faster than normal) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A physician's order dated May 16, 2025, directed Macrobid 100 mg, one tablet by mouth twice daily for three days for infection. The May 2025 MAR for Resident 78 showed that the May 17, 2025, 9:00 AM dose was not administered, with the record again coded 9. An electronic MAR note dated May 17, 2025, at 11:14 AM documented that the Macrobid was unavailable from the pharmacy and that the facility was unable to provide a reason for the unavailability. A review of Resident 82's clinical record revealed the resident was admitted to the facility February 29,2024, with diagnoses which included Unspecified Dementia (the loss of cognitive functioning that affects a person's ability to perform everyday activities). A physician's order dated May 6, 2024, prescribed Oxycodone HCL 5 mg (an opioid analgesic used to treat pain), by mouth every eight hours for shoulder pain. A review of Resident 82's MAR (medication administration record) showed that the 6:00 AM dose on May 9, 2025, was not administered and was marked with a 9. A nursing note dated May 9, 2025, at 6:07 AM documented that the medication was unavailable. Further documentation revealed the facility had not received the medication due to a need for a new prescription. The record showed that multiple attempts were made to contact the pharmacy to obtain a release code, but no return call was received. An interview with the Director of Nursing (DON) on June 13, 2025, at approximately 8:55 AM acknowledged the facility did not have adequate procedures in place to ensure medications were obtained and administered in a timely manner for Residents 49, 78 and 82. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.9 (f)(2) Pharmacy services.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on a review of select facility policy and resident and staff interviews, it was determined the facility failed to ensure that fresh drinking water was consistently readily accessible to residents to promote adequate hydration, meet resident preferences, and maintain their comfort for five of 20 residents reviewed (Residents 22, 5, 196, 76, and 83). Findings include: A review of the facility policy titled Serving Drinking Water last reviewed by the facility on May 1, 2025, indicated the facility will provide a fresh supply of drinking water. During a resident group interview on June 11, 2025, at 10:00 AM, five of five alert and oriented residents in attendance (Residents 22, 5, 196, 76, and 83) voiced concerns that fresh ice water was only consistently provided during the overnight shift (11:00 PM to 7:00 AM) and not during the day or evening shifts unless residents specifically requested it. Resident 22 stated that she enjoys drinking fresh ice water but is not provided with fresh water during the day or evening unless she asks staff to provide it. Resident 5 stated that staff provide fresh ice water late at night while she is sleeping. By the time she wakes up, the ice has melted, and the water is at room temperature. She stated she prefers her water cold, but staff do not refill the water until the next night shift. Resident 196 stated staff provide fresh ice water during the third shift only. She reported she is awakened when staff bring in fresh ice water in the middle of the night, she stated that while staff will refill the cup during the day, it only occurs if the resident asks. Residents 76 and 83 confirmed that staff provide fresh ice water overnight but not during the day or evening shifts unless requested by the resident. An interview with the Nursing Home Administrator (NHA) on June 12, 2025, at 9:50 AM, confirmed that facility protocol requires residents to receive a new water cup daily with fresh ice water during the 11:00 PM to 7:00 AM shift, and that cups are to be refilled each shift and as needed. The NHA acknowledged that the facility did not ensure fresh ice water was consistently accessible to residents during all shifts as outlined in policy and as preferred by residents. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy, clinical records, and staff interview, it was determined the facility failed to ensure pneumococcal and influenza immunizations were offered and/or provided, unless medically contraindicated or previously administered, for one of five residents reviewed (Resident 6). Findings include: A review of facility policy titled Pneumococcal Vaccine last reviewed May 1, 2025, revealed prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine. When indicated, the vaccine will be offered and be administered within 30 days of admission. Assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission if not conducted prior to admission. A review of facility policy titled Influenza Vaccine last reviewed May 1, 2025, revealed that all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccination against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents or resident representatives. Between October 1st and March 31 each year, the influenza vaccine will be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. A resident's refusal of the vaccine shall be documented on the informed consent for the influenza vaccine and placed in the resident's medical record. A review of the clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnosis to include multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves). Review of the Pneumococcal Vaccination Informed Consent Form scanned into Resident 6's electronic clinical record on January 9, 2025, did not indicate whether the resident accepted or declined the pneumococcal vaccine. Review of the Influenza Vaccination Informed Consent/Declination Form scanned into Resident 6's electronic clinical record on January 9, 2025, also failed to indicate whether the resident accepted or declined the influenza vaccine. Further review of the clinical record revealed no documented evidence that the facility identified the incomplete vaccination consent forms or reapproached the resident to determine their immunization preference. There was no documentation verifying that the vaccines were administered, declined, previously received, or medically contraindicated. An interview with the regional nurse consultant on June 13, 2025, at approximately 10:40 AM confirmed that the facility failed to offer and/or provide pneumococcal and influenza vaccinations to Resident 6 in accordance with facility policy 28 Pa. Code 201.14(a) Responsibility of licensee. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.5 (f)(iv) Medical records. 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa code 211.12 (c)(d)(1)(5) Nursing Services.