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	04/24/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined the facility failed to ensure a resident or the resident's representative was fully informed of and participated in treatment decisions related to intravenous micronutrient and hydration therapy, including the failure to provide information necessary to make an informed decision and the failure to obtain consent prior to administration of treatment for one of 22 residents reviewed (Resident 103).Findings include: A clinical record review revealed Resident 103 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood flow to the brain) and hemiplegia (paralysis on one side of the body). A review of Resident 103's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 3, 2025, revealed Section C Cognitive Patterns indicating Resident 103 has problems with short-term (recall after 5 minutes) and long-term (recall long past) memory. The assessment indicated Resident 103 was moderately cognitively impaired and required cues and supervision for making daily decisions. A clinical record review revealed a Pennsylvania Orders for Life Sustaining Treatment document dated July 20, 2024, indicating Resident 103 communicated advance care planning decisions to his physician. A Pennsylvania Orders for Life Sustaining Treatment document translates a resident's end-of-life treatment preferences into medical orders that follow the resident across healthcare settings. The primary purpose is to ensure residents receive desired treatments such as specific comfort measures, medication, or intubation and avoid unwanted interventions. The document indicated Resident 103 elected that no hydration and no artificial nutrition by tube be provided. A clinical record review revealed a physician's order dated October 28, 2025, for hydration infusion one time 500 milliliters (ml) of 0.9 percent normal saline (a sterile saltwater solution commonly used for hydration) at 250 ml per hour with directions to provide one-time micronutrient hydration therapy by an outside contracted nursing service. The order included an intravenous infusion (fluid delivered directly into a vein through a catheter) containing the following substances: B-Complex (a combination of B vitamins that support energy metabolism and nerve function).Thiamine (Vitamin B1, which helps the body use food for energy and supports nerve and muscle function). Ribo 4, identified as Riboflavin 4 milligrams (Vitamin B2, which helps the body produce energy and maintain healthy skin, eyes, and nerves). Nia 20 milligrams, identified as Niacin (Vitamin B3, which helps convert food into energy and supports the skin, nerves, and digestive system). Dex 4 milligrams, identified as Dexpanthenol (Vitamin B5, which supports healing and energy metabolism). Pyr 4 milligrams, identified as Pyridoxine (Vitamin B6, which supports blood production and energy metabolism). Methyl 2 milligrams, identified as Methylcobalamin (Vitamin B12, an active form of Vitamin B12 used by the body to support nerve function and red blood cell production). Magnesium chloride 600 milligrams (a mineral involved in muscle and nerve function). Calcium chloride 100 milligrams (a mineral important for bone strength and muscle function); and Zinc 10 milligrams (a mineral that supports immune function and wound healing). A medication administration record dated October 2025 revealed Resident 103 received intravenous micronutrient and hydration therapy with 500 ml of 0.9 percent normal saline at 250 ml per hour on October 28, 2025. A clinical record review (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documented evidence Resident 103 or Resident 103's representative was provided information regarding the risks, benefits, purpose, or alternatives related to intravenous micronutrient and hydration therapy to support an informed treatment decision. A clinical record review revealed no documented evidence Resident 103 or Resident 103's representative consented to the administration of intravenous micronutrient and hydration therapy. During an interview on April 24, 2026, at 9:30 AM, the above information was reviewed with the nursing home administrator (NHA) and regional nurse consultant (RNC). The NHA and RNC were unable to provide documented evidence Resident 103 or Resident 103's representative was informed of and provided an opportunity to participate in the decision-making process regarding intravenous micronutrient and hydration therapy. The NHA and RNC were further unable to provide documented evidence Resident 103 or Resident 103's representative consented to the treatment prior to administration. The facility failed to ensure Resident 103 was fully informed of and able to participate in treatment decisions regarding intravenous micronutrient and hydration therapy administered on October 28, 2025. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.2 (d)(7) Medical director. 28 Pa. Code 211.12 (d)(3) Nursing services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of employee personnel files, select facility policies, external contract agreements, and staff interviews, it was determined the facility failed to fully implement abuse prohibition procedures to ensure the facility did not employ or otherwise engage individuals who may have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law for one of six employees reviewed (Employee 9). Findings include: A review of the facility policy titled Abuse Policy, last reviewed by the facility on January 1, 2026, revealed residents have the right to be free from abuse, neglect, misappropriation of property, corporal punishment, and involuntary seclusion. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. The facility will conduct background investigations and reference checks to avoid hiring persons who have been found guilty by a court of law of abusing, neglecting, or mistreating individuals or those who have had a finding of such action entered into the state nurse aide registry or state sex offender registry. The policy indicated the facility will contact the last place of employment and obtain criminal background checks in accordance with state requirements. The policy indicated if an applicant had not been a resident of Pennsylvania for two continuous years prior to employment, the facility would obtain a Federal Bureau of Investigation (FBI) criminal background check within 90 days of hire and obtain a Pennsylvania State Police criminal history background check within 30 days of hire. In accordance with Pennsylvania Act 13 of 1997, known as the Older Adults Protective Services Act, and Pennsylvania Act 169 of 1996, relating to criminal history background checks, nursing facilities are required to obtain criminal history background information for prospective employees. These requirements include obtaining a Pennsylvania State Police criminal history record check within 30 days of hire. If an individual has not maintained continuous Pennsylvania residency for the two years immediately preceding employment, the facility is also required to obtain a Federal Bureau of Investigation (FBI) criminal history background check within 90 days. A review of an external contract agreement between the facility and an external intravenous therapy services company dated August 15, 2025, revealed the external company was responsible for conducting background checks and federal program exclusion screenings on all associates with direct resident contact or access to resident records at the facility. The agreement indicated background checks shall cover the previous seven years of employment, and would be conducted in accordance with applicable state law or, in the absence of state law, checks must be obtained within two months of the date of employment for all states that the individual has lived or worked in the past three years, be based on information provided by the appropriate state or local law enforcement agency, if so required by applicable state law; and would include verification through federal exclusion databases including the Office of Inspector General (OIG), System for Award Management (SAM), List of Excluded Individuals/Entities (LEIE), and applicable State Medicaid and Medicare exclusion databases. Based on a review of clinical records, Employee 9, External Registered Nurse, provided care to residents in the facility and accessed resident's medical records on October 27, 2025, and October 28, 2025. During an interview on April 24, 2026, at 9:30 AM, the Nursing Home Administrator (NHA) and Regional Nurse Consultant (RNC) stated the external intravenous therapy company maintained Employee 9's personnel records. The NHA and RNC provided personnel records for Employee 9 for review. Review of the records provided by the facility failed to show evidence Employee 9 had a Pennsylvania State Police criminal history clearance through the Pennsylvania Access to Criminal History (PATCH) system, the state-operated criminal background check system used for employment, licensing, and volunteer screening purposes. The facility failed to fully implement abuse prohibition procedures and failed to ensure required criminal background screening documentation was obtained and maintained for Employee 9 prior to permitting the employee to provide resident care and access resident medical records within the facility. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(8) Personnel records.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, information submitted by the facility, the facility's abuse prohibition policy, and staff interviews, it was determined the facility failed to accurately and completely report, document, and investigate an allegation of abuse to identify the alleged perpetrator and ensure resident protection measures were implemented in accordance with federal and state reporting requirements for one of 22 residents reviewed (Resident 81).Findings include: A review of the facility policy titled Abuse Policy, last reviewed by the facility on January 1, 2026, revealed it is the facility policy to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA), 6703(b)(s). Specifically, it is the facility's policy to report immediately, but no later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or no later than 24 hours if the event that causes suspicion did not result in serious bodily injury. Report any occurrences of abuse, neglect, misappropriation of resident property, and suspicions of crime to the State Survey Agency, local Department of Aging, and local law enforcement entities for the political subdivisions in which the facility is located. Act 13 of 1997 requires an employee or administrator of a facility who has reasonable cause to suspect that a recipient is a victim of abuse to immediately report the abuse. The law requires oral reports to the Area Agency on Aging (AAA). In addition, reports must be made to the Pennsylvania Department of Aging (PDA) and local law enforcement for suspected abuse involving serious bodily injury, serious physical injury, sexual abuse, or suspicious death circumstances. The Pennsylvania state event notification overview dated March 16, 2021, directed facilities to complete mandatory state reporting forms for all allegations of staff-to-resident physical abuse. A clinical record review revealed that Resident 81 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of information provided by the facility dated March 30, 2026, revealed the facility investigated allegations that Resident 81 stated she had been hit in the right shoulder by a woman. The facility documented that based on resident and staff witness statements, resident assessment findings, and the facility investigation, the allegation of physical abuse could not be substantiated. However, a witness statement dated March 31, 2026, revealed Employee 6, nurse scheduler, documented that Resident 81 identified the assistant director of nursing's daughter, Employee 10, agency Licensed Practical Nurse (LPN), as the person who hurt the resident's arm. The witness statement documented Resident 81 complained of pain to her right upper arm. During an interview on April 22, 2026, at 1:47 PM, Employee 6 confirmed Resident 81 identified Employee 10, agency LPN, as the individual who hurt her arm. During an interview on April 24, 2026, at 9:30 AM, the above information was reviewed with the nursing home administrator (NHA) and regional nurse consultant (RNC). The NHA and RNC confirmed the facility's submitted reports and investigative documentation did not identify Employee 10 as the alleged perpetrator. The NHA and RNC further indicated the facility investigation concluded there was no alleged perpetrator identified. The facility failed to accurately and completely report and document the allegation of abuse after Resident 81 identified a specific staff member (Employee 10 LPN) as the alleged perpetrator. The facility failed to thoroughly investigate the allegation to determine whether Employee 10 was involved in the alleged incident and failed to ensure complete reporting information was provided to the State Survey Agency and the Area Agency on Aging to support appropriate oversight and resident protection. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies.

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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, the Resident Assessment Instrument (RAI) Manual, Minimum Data Set (MDS) assessments, and staff interview, it was determined the facility failed to ensure MDS assessments accurately reflected residents' clinical status for two of 22 residents reviewed (Residents 112 and 103).Findings include: The Resident Assessment Instrument (RAI) Manual is the federally issued instruction manual that provides specific coding guidance for each item on the Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care). Facilities are required to complete and code MDS assessments in accordance with the RAI Manual to ensure assessments accurately reflect a resident's condition, care needs, and services provided. A review of Resident 112's closed clinical record revealed Resident 112 was admitted to the facility on [DATE], with diagnoses that included moderate protein-calorie malnutrition (a condition in which an individual does not receive enough protein and calories to maintain health). A physician order dated October 27, 2025, at 5:58 PM, written by the facility's Certified Registered Nurse Practitioner (CRNP), directed a one-time intravenous micronutrient hydration therapy to be administered by an outside contracted nursing service. The order included an intravenous infusion (fluid delivered directly into a vein through a catheter) containing the following substances:B-Complex (a combination of B vitamins that support energy metabolism and nerve function).Thiamine (Vitamin B1, which helps the body use food for energy and supports nerve and muscle function). Ribo 4, identified as Riboflavin 4 milligrams (Vitamin B2, which helps the body produce energy and maintain healthy skin, eyes, and nerves). Nia 20 milligrams, identified as Niacin (Vitamin B3, which helps convert food into energy and supports the skin, nerves, and digestive system). Dex 4 milligrams, identified as Dexpanthenol (Vitamin B5, which supports healing and energy metabolism). Pyr 4 milligrams, identified as Pyridoxine (Vitamin B6, which supports blood production and energy metabolism). Methyl 2 milligrams, identified as Methylcobalamin (Vitamin B12, an active form of Vitamin B12 used by the body to support nerve function and red blood cell production). Magnesium chloride 600 milligrams (a mineral involved in muscle and nerve function). Calcium chloride 100 milligrams (a mineral important for bone strength and muscle function); and Zinc 10 milligrams (a mineral that supports immune function and wound healing). These substances are classified as vitamins or micronutrients. Vitamins are organic compounds required in small amounts for normal body function and are typically obtained through diet or oral supplements. Vitamins are not considered parenteral nutrition (intravenous feeding that provides calories, protein, fats, carbohydrates, vitamins, and minerals as a primary nutritional source). The micronutrients were added to 500 milliliters (ml) of 0.9 percent normal saline (a sterile saltwater solution commonly used for hydration) and infused at 500 ml per hour on October 28, 2025. A review of the October 2025 Medication Administration Record (MAR) revealed the infusion was administered and completed on October 28, 2025, at 8:15 AM. The RAI Manual for Section K0520, Nutritional Approaches, Parenteral/IV Feeding instructs that parenteral feeding refers to nutrition provided intravenously when a resident cannot receive adequate nutrition through oral intake or the gastrointestinal tract. The manual further instructs that intravenous fluids administered solely for hydration purposes or fluids used to dilute medications are not to be coded as parenteral/IV feeding. A review of Resident 112's interim payment assessment (IPA) MDS (a type of evaluation to help decide how much Medicare will pay for a resident's care; an IPA is not routine and only done when the facility chooses to complete the interim MDS) dated [DATE], revealed: Section K0520 (Parenteral/IV Feeding) was coded yes, indicating the resident received IV feeding during the seven-day look-back period (the seven days preceding the assessment reference date). Section K0710A (Percent Intake by Artificial Route) was coded to indicate the resident received 25 percent or less of total calories through parenteral or tube feeding during the look-back period. Section K0710B (Average Fluid Intake by (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Artificial Route) was coded to indicate the resident received 500 ml or less per day by IV or tube feeding during the look-back period. However, review of the clinical record revealed documentation of a one-time intravenous hydration infusion containing vitamins and minerals added to normal saline. The clinical record did not contain documentation the infusion provided calories as a primary nutritional source, replaced oral intake, or constituted parenteral nutrition as defined by the RAI Manual. Therefore, the coding of Sections K0520 and K0710 on the October 31, 2025, MDS assessment was not supported by the clinical record or RAI Manual instructions. A review of Resident 103's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage caused by interrupted blood flow to the brain) and hemiplegia (paralysis affecting one side of the body). A physician order dated October 28, 2025, directed administration of a one-time intravenous micronutrient hydration therapy consisting of vitamins and minerals mixed in 500 ml of 0.9 percent normal saline administered at 250 ml per hour by an outside contracted nursing service. The order included an intravenous containing the following substances: B-Complex (a combination of B vitamins that support energy metabolism and nerve function).Thiamine (Vitamin B1, which helps the body use food for energy and supports nerve and muscle function). Ribo 4, identified as Riboflavin 4 milligrams (Vitamin B2, which helps the body produce energy and maintain healthy skin, eyes, and nerves). Nia 20 milligrams, identified as Niacin (Vitamin B3, which helps convert food into energy and supports the skin, nerves, and digestive system). Dex 4 milligrams, identified as Dexpanthenol (Vitamin B5, which supports healing and energy metabolism). Pyr 4 milligrams, identified as Pyridoxine (Vitamin B6, which supports blood production and energy metabolism). Methyl 2 milligrams, identified as Methylcobalamin (Vitamin B12, an active form of Vitamin B12 used by the body to support nerve function and red blood cell production). Magnesium chloride 600 milligrams (a mineral involved in muscle and nerve function). Calcium chloride 100 milligrams (a mineral important for bone strength and muscle function); and Zinc 10 milligrams (a mineral that supports immune function and wound healing). A review of the October 2025 MAR revealed Resident 103 received the intravenous micronutrient hydration infusion on October 28, 2025. A review of Resident 103's quarterly MDS assessment dated [DATE], revealed that: Section K0520 A (Parenteral/IV Feeding) was coded 1, indicating parenteral or IV feeding was performed at the facility during the seven-day look-back period. Section K0710A (Percent Intake by Artificial Route) was coded to indicate the resident received 25 percent or less of total calories through parenteral or tube feeding during the look-back period. Section K0710B (Average fluid intake per day by IV or tube feeding) was coded to indicate the resident received 500 ml or less per day by IV or tube feeding during the look-back period. However, review of Resident 103's clinical record revealed documentation of a one-time intravenous micronutrient hydration infusion consisting primarily of vitamins, minerals, and amino acids added to normal saline. The record did not contain documentation that the infusion provided calories as a primary nutritional source, replaced oral intake, or constituted artificial nutritional support as defined under parenteral feeding in the RAI Manual. Therefore, the coding of Sections K0520 and K0710 on the November 3, 2025, MDS assessment was not supported by the clinical record or RAI Manual instructions. During an interview on April 24, 2026, at 9:30 AM, the above information was reviewed with the Nursing Home Administrator (NHA) and Regional Nurse Consultant (RNC). The facility indicated it identified and corrected the inaccurate coding for Resident 103 in March 2026. The facility also acknowledged inaccuracies related to Resident 112's October 31, 2025, MDS assessment. The facility failed to ensure the MDS assessments accurately reflected the status of Residents 103 and 112. 28 Pa. Code 211.5(f)(ix) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered or evaluated the need for a prescribed medication according to physician-ordered parameters for two of 22 residents reviewed (Resident 4 & Resident 12).Findings include: A review of the facility policy titled Administering Medications last reviewed on January 1, 2026, revealed the purpose of the policy was to ensure safe and effective administration of medication and as prescribed. The policy required medications to be administered in accordance with the provider's written or verbal orders after verification of the right medication, right dose, right route, right time, and confirmation of the resident's identity, and only when no contraindications (a clinical reason a medication should not be given because it may cause harm) were present. The policy required the verification of vital signs (measurements that show how well the body is working) prior to administering medications, if necessary. Resident 4 was admitted to the facility on [DATE], with diagnosis which included cerebral infarction (an area of brain tissue that dies because its blood supply has been blocked). A review of Resident 4's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 9, 2026, revealed that Resident 4 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 intact cognitive function, reflecting normal memory, orientation, and recall abilities). A review of Resident 4's clinical record revealed a physician order dated February 4, 2026, for Midodrine HCl (medication that helps to raise low blood pressure, especially when the blood pressure is lowered when one stands up from a seated or lying position) 5 milligrams (mg) daily by mouth every eight hours as needed for hypotension (low blood pressure). The order indicated the medication was to be held if Resident 4's systolic blood pressure (top number in a blood pressure reading that measures how much pressure is in the arteries when the heart beats and pushes blood out to the rest of the body) was greater than 100 mmHg (millimeters of mercury, unit of measurement for blood pressure). Review of the electronic medication administration record (eMAR, the legal record used to document medications administered) revealed that during the time the medication was ordered (February 4, 2026, until March 11, 2026), Midodrine was not administered and the blood pressure was not obtained every eight hours to determine the need for the medication. Resident 12 was admitted to the facility on [DATE], with diagnosis which included primary generalized osteoarthritis (a condition that occurs when cartilage that cushions the ends of bones gradually breaks down, leading to pain, stiffness, swelling, and reduced joint mobility) and tachycardia (heart is beating faster than normal). A review of Resident 12's quarterly Minimum Data Set assessment (MDS), dated [DATE], revealed that Resident 12 was cognitively intact with a BIMS score of 13 which indicates intact cognitive function, reflecting normal memory, orientation, and recall abilities. A review of Resident 12's physician order dated November 5, 2025, revealed an order for Metoprolol Succinate 12.5 milligrams Extended-Release tablet (medication used to treat high blood pressure), orally, every day. The order revealed the medication was not to be administered if the systolic blood pressure was less than 90 mm/Hg or the heart rate was less than 60 heart beats per minute. Clinical record review of the electronic medication administration (eMAR revealed that from November 5, 2026, until November 12, 2026, Resident 12's heart rate was not assessed prior to administering Metoprolol Succinate 12.5 milligrams Extended-Release tablet to determine if the medication was safe to administer. An interview with the Regional Administrator of Clinical Operations on April 22, 2026, at 9:55 AM and again on April 23, 2026, at 9:20 AM confirmed the required, vital signs were not obtained and evaluated for medication administration according to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders and facility policy for both Resident 4 and Resident 12. 28 Pa. Code 211.5(f)(ii)(ix) Medical records. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(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 clinical record review, review of the facility's restorative nursing policy, staff interviews, and resident interview, it was determined the facility failed to implement and evaluate an individualized restorative nursing program with measurable resident-centered goals, resident participation in care planning, and ongoing reevaluation to modify the program as necessary for one of 22 sampled residents (Resident 13).Findings include: Clinical record review revealed Resident 13 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (a condition in which the body is unable to properly regulate blood sugar levels due to problems producing or using insulin) and obesity (excess body weight that may impair mobility and physical functioning). A review of Resident 13's quarterly Minimum Data Set assessment, (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 3, 2026, revealed that Resident 13 was cognitively intact with a BIMS score of 15, (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to15 indicates intact cognition). A review of the facility's Restorative Nursing Services policy, reviewed January 1, 2026, revealed that restorative goals and objectives are individualized and resident-centered and are outlined in the resident care plan. The resident will be included in determining goals and the plan of care. In addition, restorative goals may include, but are not limited to, supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining, or strengthening physiological resources; maintaining dignity, independence, and self-esteem; and participating in the development and implementation of their plan of care and their restorative program. An interview with the resident on April 21, 2026, at 11:00 AM revealed that Resident 13 had a desire to get stronger so that a discharge to home would be possible. The resident indicated that he was receiving restorative nursing services on a daily basis, but this service was not being done or was not effective to meet his needs to get stronger. The resident indicated that restorative staff document that he is receiving restorative services, but he is not being offered these services to enhance his ability to strengthen on a consistent basis to become independent enough to go home. The resident indicated that he was not included in the decision-making process as to when these services could be completed or what exercises would be beneficial and did not receive periodic updates or suggested changes in the program or his comfort level with the program and modifications, which may allow him to make gradual improvement towards independence. A review of a physical therapy Discharge summary dated [DATE], revealed the resident was discharged from therapy services to a restorative nursing program to maintain current level of functioning. During an interview on April 22, 2026, at 2:45 PM, Employee 1, an occupational therapist, indicated that at the time of discharge from physical therapy on August 29, 2025, Resident 13 ambulated (walked) 25 feet using a front-wheeled walker. During an interview on April 23, 2026, at 10:15 AM, Employee 2, an occupational therapist, indicated the restorative nursing program was intended to include bed positioning and mobility activities, including rolling side to side and sitting at the edge of the bed. Employee 2 indicated the resident's ability to roll in bed had declined since March 3, 2026. Review of Resident 13's care plan dated March 3, 2026, revealed there was no individualized restorative nursing care plan identifying the specific restorative program interventions, exercises to be completed, duration or frequency of the exercises, measurable goals, methods to evaluate progress, or interventions directed toward the resident's stated goal of improving strength and independence for possible discharge home. During an interview on April 22, 2026, at 2:30 PM, Employee 3, nurse aide, was unable to explain how the facility evaluated Resident 13's restorative nursing program to determine whether modifications were necessary to meet the resident's specific goals or changing physical abilities. Review of March 2026 restorative nursing documentation (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed staff documented Resident 13 refused restorative services 17 times on day shift and 10 times on evening shift. The documentation did not identify reasons for the refusals, resident concerns, or attempts to modify the program to improve participation. In addition, documentation for completed restorative services failed to include the amount of time services were provided, making it unable to determine whether the restorative program was effective in maintaining, improving, or declining the resident's physical functioning and whether modifications to the program were necessary. There was no evidence that the restorative nursing program incorporated resident choice regarding preferred times for participation, preferred exercises, gradual progression of activities, or other individualized approaches intended to support the resident's stated goal of improving independence with the main goal of achieving the resident's wishes to be independent at home. During an interview on April 24, 2026, at 11:00 AM, the Nursing Home Administrator was unable to provide documented evidence the facility maintained ongoing restorative nursing documentation demonstrating measurable results, resident-centered goals and expectations, evaluation of the effectiveness of the program, or modifications to the restorative program based on the resident's progress, refusals, declining functioning, or stated preferences. 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure a resident who entered the facility with an indwelling urinary catheter was assessed for catheter removal at the earliest possible time unless the resident's clinical condition demonstrated that continued catheterization was necessary for one of 22 residents reviewed (Resident 11). Findings include: A clinical record review revealed Resident 11 was most recently admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Review of physician orders revealed an order dated February 19, 2026, for a Foley catheter (a flexible tube inserted through the urethra into the bladder to continuously drain urine into a collection bag) size 16 French (a catheter measurement indicating the diameter of the tube) with a 30 cubic centimeter (cc) balloon (an inflatable retention balloon used to keep the catheter in place inside the bladder) to straight bag gravity drainage (urine drainage into a collection bag using gravity rather than suction) for neurogenic bladder (a bladder dysfunction caused by nerve damage that affects the bladder's ability to properly store or empty urine). A care plan indicating Resident 11 has a need for an indwelling catheter related to neurogenic bladder initiated on March 6, 2026. Interventions to ensure Resident 11 is free from catheter-related complications include reviewing with the resident and resident representative the risks of catheterization and providing catheter care every shift and as needed. Further clinical record review revealed no documented evidence the facility assessed Resident 11 for catheter removal or evaluated whether continued catheterization remained clinically necessary following the resident's admission to the facility on December 10, 2025. During an interview conducted on April 24, 2026, at 9:30 AM, the above information was reviewed with the nursing home administrator (NHA) and regional nurse consultant (RNC). The NHA and RNC were unable to provide documented evidence the facility assessed Resident 11's ongoing need for catheterization or documented evidence the resident's clinical condition demonstrated that continued catheterization was necessary. Following surveyor inquiry during the survey, the facility obtained a physician order scheduling Resident 11 for an appointment with an external urology specialist (a physician specializing in the urinary tract and related conditions) on April 30, 2026, at 11:00 AM. 28 Pa. Code 211.10(a) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 clinical records, select facility policies, and staff interviews, it was determined the facility failed to timely identify changes in nutritional parameters, implement appropriate nutritional interventions, and notify the attending physician and the resident regarding significant weight loss for one of 22 residents reviewed (Resident 5). Findings included: A review of a facility policy entitled Weight Assessment and Intervention, last reviewed by the facility January 1, 2026, indicated resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Any weight change of 5 pounds (if the resident weight is greater than 100 pounds) or 3 pounds (if the resident weight is less than 100 pounds), or more, since the last weight assessment will constitute a re-weight for validation. If the weight is verified as requiring evaluation, nursing will notify the registered dietician. Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria 1 month- 5 percent weight loss is significant; greater than 5 percent is severe. 3 months- 7.5 percent weight loss is significant; greater than 7.5 percent is severe. And 6 months- 10 percent weight loss is significant; greater than 10 percent is severe. A review of a facility policy entitled Change in a Resident's Condition or Status, last reviewed by the facility January 1, 2026, indicated the facility will promptly notify the resident, their attending physician, and the resident representative of changes in the resident's changes in the resident's medical or mental condition or status. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself with intervention by staff or by implementing standard disease-related clinical intervention and required interdisciplinary review and or revision to the care plan. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical or mental condition or status. A review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying life-threatening events) and major depressive disorder (a mental health condition characterized by persistent low mood and loss of interest in usual activities). A review of Resident 5's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 2, 2026, 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 through 15 indicates cognition is intact). A review of Resident 5's weight record revealed the following documented weights: February 1, 2026: 125.3 poundsMarch 1, 2026: 115.4 poundsMarch 23, 2026: 117.4 poundsMarch 30, 2026: 116.2 poundsApril 1, 2026: 116.2 poundsApril 13, 2026: 114.8 poundsApril 20, 2026: 114.2 pounds The March 1, 2026, weight reflected a loss of 9.9 pounds, representing 7.9 percent body weight loss in one month. The clinical record revealed a re-weight to verify the significant weight loss was not obtained until 22 days later. A review of a nutrition note completed by the facility's Registered Dietitian (RD) dated March 22, 2026, at 8:00 AM, in response to a weight warning for the March 1, 2026, value, recommended obtaining a reweight, which then confirmed a documented weight loss of 7.9 percent (9.9 pounds), and reflected underweight status for the resident. The RD noted the resident was receiving a vegetarian diet with regular textures and thin liquids, with ice cream provided with lunch and dinner meals, with good intakes of 51-100 percent. The RD recommended fortified foods with all meals to increase calorie and protein intake with a goal of weight stability and weight gain. A review of a nurse progress note dated March 22, 2026, at 9:47 PM, revealed new orders were obtained from the physician for weekly weights related to weight management and documented the resident was (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their own resident representative. A review of physician orders revealed an order dated March 22, 2026, for weekly weights. A review of physician orders revealed an order dated March 24, 2026, at 9:54 AM, for a regular texture, thin consistency, renal diet (a diet modified to reduce certain nutrients to support kidney function), ice cream with lunch and dinner trays, fortified foods with meals, and continuation of the resident's vegetarian diet preference. The interventions were implemented two days after the RD recommendation. A review of a weight warning note completed by the RD dated April 21, 2026, at 1:23 PM, in response to a weight alert for the April 20, 2026, value, documented continued weight loss of 8.9 percent (11.1 pounds) since February 1, 2026, and recommended providing a health shake with breakfast to provide an additional 200 calories and 6 grams of protein related to progressive weight loss. A review of physician orders revealed an order dated April 21, 2026, at 1:29 PM, to provide a daily health shake with breakfast due to risk for malnutrition (a condition resulting from inadequate or imbalanced nutritional intake needed to maintain normal body function and health). The clinical record failed to reveal documented evidence Resident 5's attending physician and the resident were notified of the significant weight loss identified on March 1, 2026. Additionally, the clinical record failed to reveal documented evidence recommended nutritional interventions, including fortified foods with meals, were implemented timely following identification of the resident's significant weight loss. During an interview with the regional nurse consultant on April 23, 2026, at 12:30 PM, the above findings were reviewed. The regional nurse consultant confirmed no additional documentation could be provided demonstrating timely physician or resident notification regarding the identified significant weight loss or timely implementation of recommended nutritional interventions. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

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F 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 a review of clinical records, facility policy, and staff interviews, it was determined the facility failed to ensure intravenous therapy was provided and monitored in accordance with physician orders and professional standards of practice for two of 22 residents reviewed (Residents 1 and 30) who required care and monitoring of a Peripherally Inserted Central Catheter (PICC) line. Findings include: Review of the facility policy entitled, Central Venous Catheter Care and Dressing Changes, last reviewed January 1, 2026, indicated the purpose of the procedure is to avoid complications associated with intravenous therapy (delivery of fluids or medications directly into a vein), including catheter-related infections (infections that occur when bacteria enter the bloodstream through a catheter, which is a tube placed into a vein) that are associated with contaminated, loosened, soiled, or wet dressings. The guidelines included information indicating staff are to check the State's Nurse Practice Act for Licensed Practical Nurses (LPN), regarding scope of practice (the tasks the nurse is legally allowed to perform) for care of central venous catheter dressings. The policy indicated intravenous site care and dressing changes are required at established intervals or immediately if the integrity of the dressing is damp, loosened, or visibly soiled. The guidelines revealed the length of the external central vascular access device (the portion of the catheter visible outside the body) should be measured with each dressing change, or if catheter dislodgement (movement of the catheter out of its proper position) is suspected. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnosis that included chronic obstructive pulmonary disease (COPD, a long term lung condition in which airflow is persistently blocked due to chronic inflammation and structural damage in the lungs, making it difficult to breathe). A review of Resident 1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 20, 2026, revealed that Resident 1 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 intact cognitive function, reflecting normal memory, orientation, and recall abilities). A review of the Admission/readmission documentation dated January 22, 2026, revealed Resident 1 was admitted with a Peripherally Inserted Central Catheter (PICC line, a long, thin tube inserted into a vein in the upper arm and advanced to a large vein near the heart to deliver medications, fluids, or nutrition over an extended period) for antibiotic (medication to help fight infection) administration. A physician's order dated January 22, 2026, required staff to measure, in centimeters (cm, a unit of length in the metric system), the length of the external PICC line from the insertion site (the portion closest to the resident's skin) to the port (the portion furthest from the resident) daily and as needed. A review of the electronic medication administration record (eMAR, the electronic system used to document medications and related treatments administered to residents) revealed no documentation of PICC line measurements for Resident 1 on February 5, February 11, February 24, February 25, and February 26, 2026, as ordered. A clinical record review revealed Resident 30 was admitted to the facility on [DATE], with diagnoses that included chronic multifocal osteomyelitis of the left ankle and foot (a persistent bone infection affecting multiple areas of the bone). A review of Resident 30's quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 30 was cognitively intact with a BIMS score of 13. A clinical record review revealed Resident 30 was admitted from the acute care facility on March 2, 2026, with a Peripherally Inserted Central Catheter (PICC) line inserted for antibiotic administration. A physician's order dated March 4, 2026, required daily measurement and as needed, in centimeters, of the external length of the PICC line from the insertion site to the port. A review of Resident 30's electronic treatment record revealed no documentation of PICC line measurements on March 14, March 15, and March 21, 2026. Review of physician orders dated March 5, 2026, required PICC line dressing and cap (protective sterile covering (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and connector at the end of the catheter) changes every seven days. A review of the electronic treatment administration record revealed no documentation that PICC line dressing and cap changes were completed at the required seven-day intervals for Resident 30. Failure to measure the PICC line as ordered limited the facility's ability to identify potential catheter displacement (movement out of proper position) in a timely manner, placing residents at risk for complications. Failure to complete and document PICC line dressing and cap changes as ordered increased the risk for infection and compromised the integrity of the catheter site. During an interview on April 22, 2026, at 9:45 AM, the Regional Administrator of Clinical Operations stated the facility did not consistently monitor and maintain PICC lines in accordance with physician orders, facility policy, and professional standards of practice for Residents 1 and 30. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, review of facility staffing schedules, and staff and resident interviews, the facility failed to provide sufficient nursing staff with the appropriate competencies to ensure timely and quality care and services for two of 22 residents reviewed (Residents 10 and 14). Findings include: A review of nurse scheduling assignments revealed the facility failed to meet the minimum nurse aide to resident ratio requirement on five of 21 shifts reviewed. The facility failed to meet the minimum state requirements for nurse aides on the following dates: January 25, March 29, and April 20, 2026. A review of nurse scheduling assignments revealed the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratio requirement on nine of 21 shifts reviewed. The facility failed to meet the minimum state requirements for licensed practical nurses on the following dates: January 19, January 20, January 23, January 25, March 28, and April 23, 2026. A clinical record review revealed Resident 10 was admitted to the facility on [DATE], with diagnoses that include 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) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of Resident 10's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 9, 2026, revealed the resident was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A review of the care plan initiated March 8, 2026, revealed Resident 10 required assistance with activities of daily life (ADLs, fundamental self-care tasks required for independent living such as bathing, dressing, toileting, and feeding oneself) including bed mobility with one staff member, transfers with two staff members, and assistance with toileting as needed.A review of the care plan initiated March 8, 2026, revealed Resident 10 required assistance with activities of daily life (ADLs, fundamental self-care tasks required for independent living such as bathing, dressing, toileting, and feeding oneself) self-care performance deficit related to generalized weakness and neuropathy (a nerve problem that can cause pain, numbness, tingling, swelling, or muscle weakness in different parts of the body). Interventions implemented to assist the resident with ADLs include bed mobility assistance of one staff member, transfers with two staff members, and assisting with activities of daily living as needed. During an observation on April 22, 2026, at 8:33 AM, Resident 10 was in bed and stated he had been waiting approximately ten minutes for assistance after activating his call bell for help off a bedpan. At that time, Employee 11, LPN, was observed standing outside the room near a medication cart. At 8:46 AM, Employee 12, nurse aide (NA), entered the room and at 8:47 AM assisted Resident 10 off the bedpan. Employee 11 remained outside the room during this time. When exiting the resident's room at 8:47 AM, Employee 11, LPN, remained outside of the resident's room, standing near the medication cart. It was also noted that Employee 13, LPN, was at the nurse's desk and stated that when a resident rings their call bell, it alerts them at the desk on a control panel. The resident whose call bell has rung will light up after it is pressed, which remains active until the call is answered. Review of the facility-provided staffing assignment for April 22, 2026, revealed three nurse aides and one LPN were assigned to provide care for Resident 10 in the East Long Hall on the day shift. A clinical record review revealed Resident 14 was admitted to the facility on [DATE], with diagnoses that include rheumatoid arthritis (a chronic, progressive autoimmune disorder where the immune system mistakenly attacks the joints, causing painful swelling, stiffness, and damage) and schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interactions). A review of the care plan revealed Resident 14 required assistance from two staff members for all transfers (from bed to chair or chair to bed) and ADLs related to rheumatoid arthritis and generalized weakness. A review of Resident 14's quarterly MDS dated [DATE], revealed that Resident 14 was cognitively intact with a BIMS score of 15 indication intact cognition. During an observation on April 21, 2026, at 9:50 AM, Resident 14 was in her bed. Resident 14 indicated that she has been waiting for staff to assist her out of bed since about 7:20 AM. At 10:01 AM, Employee 4, LPN, entered the room, administered medications, and acknowledged the resident's call light was active. The LPN stated the resident would need to wait until two nurse aides were available, as the assigned nurse aide was on break. During an interview on April 21, 2026, at 10:15 AM, Employee 5, nurse aide (NA), explained that another nurse aide had completed her break and now they would assist Resident 14 out of bed. Employee 5, NA, confirmed Resident 14 asked to get out of bed during breakfast (around 7:30 AM), but staff were busy assisting with passing out meals and were unable to get her out of bed at that time. Employee 5, NA, indicated that Resident 14 required two staff members for assistance to get out of bed, and now they have two nurse aides available to assist the resident. Employee 5, NA, explained that there are many residents that need care on the unit. During an interview on April 24, 2026, at 9:30 AM, the above information was reviewed with the Nursing Home Administrator (NHA), who was unable to provide an explanation for the delays in care. The facility did not provide sufficient nursing staff to meet resident needs, resulting in delays in toileting assistance for Resident 10 and a delay of approximately two hours and 15 minutes for Resident 14 to receive assistance out of bed. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(6) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(3)(4)(i)(2) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **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 ensure the pharmacist conducted medication regimen reviews at least monthly for one resident out of five reviewed (Resident 42).Findings include: A review of a facility policy entitled Medication Regimen Reviews, last reviewed by the facility on January 1, 2026, indicated the facility's consultant pharmacist reviews the medication regimen review (MRR) for every resident in the facility at least monthly. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and re-solve medication-related problems, medication errors, and other irregularities, for example, medications ordered in excessive doses or without clinical indication; medication regimens that appear inconsistent with the resident's stated preferences; duplicative therapies or omissions of ordered medications; inadequate monitoring for adverse consequences; potentially significant drug-drug or drug-food interactions; potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences; incorrect medications, administration times, or dosage forms; or other medication errors, including those related to documentation. A review of Resident 42's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include 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) and post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events). A review of Resident 42's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 28, 2026, 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 through 15 indicates cognition is intact). A review of Resident 42's clinical record conducted at the time of the survey ending April 24, 2026, and of MRR conducted between June 2025 and March 2026, revealed that the pharmacist had not conducted MRR during the months of June 2025, August 2025, September 2025, and October 2025. During an interview with the Regional Nurse Consultant on April 24, 2026, at 11:00 A.M, confirmed there was no evidence the pharmacist conducted monthly medication regimen reviews as required for Resident 42. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.28 Pa. Code: 211.9(k) Pharmacy services.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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	04/24/2026

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 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 a review of select facility policy, clinical records, and a staff interview, it was determined the facility failed to offer pneumococcal immunization in accordance with facility policy and current Centers for Disease Control and Prevention (CDC) recommendations, unless medically contraindicated or the resident had already been fully immunized, for one of five residents reviewed (Resident 81).Findings include: A review of facility policy titled Pneumococcal Vaccine, reviewed by the facility on January 1, 2026, revealed that it is the facility's policy to offer pneumococcal vaccines (vaccines that protect against infections caused by Streptococcus pneumoniae, including pneumonia, bloodstream infections, and meningitis) to aid in preventing pneumonia or pneumococcal infections. The policy indicated the administration of pneumococcal vaccines or re-vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. A review of CDC Pneumococcal Vaccination Recommendations for individuals aged 50 years or older (2025) revealed that individuals who previously received PPSV23 (pneumococcal polysaccharide vaccine, a vaccine that protects against 23 types of pneumococcal bacteria) should receive one of the following at least one year after the PPSV23 dose:PCV15 (15-valent pneumococcal conjugate vaccine, protects against 15 types of pneumococcal bacteria), orPCV20 (20-valent pneumococcal conjugate vaccine), orPCV21 (21-valent pneumococcal conjugate vaccine). A clinical record review revealed that Resident 81 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A clinical record review revealed Resident 81 was [AGE] years old and received a PPSV23 vaccine on September 1, 2024.A clinical record review revealed no additional documentation of pneumococcal immunization for Resident 81. A clinical record review revealed no evidence that Resident 81 or the resident's legal representative was offered additional pneumococcal vaccination in accordance with current CDC recommendations. Specifically, there was no documented evidence that the resident or representative was provided education or information necessary to make an informed decision regarding receipt of PCV15, PCV20, or PCV21. During an interview on April 24, 2026, at 9:30 AM, the above information was reviewed with the nursing home administrator (NHA) and regional nurse consultant (RNC). The NHA and RNC were unable to provide evidence that Resident 81 or the resident's representative was offered pneumococcal vaccination or educated regarding pneumococcal immunization in accordance with current CDC recommendations. 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa code 211.12 (d)(3)(5) Nursing Services.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, employee personnel records, facility policies and procedures, and staff interviews, it was determined the facility failed to develop, implement, and maintain an effective training program to ensure licensed nursing staff possessed the knowledge and competencies necessary to safely manage a peripherally inserted central catheter (PICC line) for two of 22 residents reviewed (Residents 1 and 30).Findings include: Federal regulation requires a facility to develop, implement, and maintain an effective training program for all new and existing staff. The training program must be based on the facility assessment (an evaluation conducted by the facility to identify the resident population and determine the knowledge and skills staff need to meet resident care needs). Pennsylvania State Board of Nursing Regulations (Title 49, Chapter 21) requires licensed nurses performing intravenous therapy, including care involving PICC lines, complete appropriate education, receive supervised clinical instruction, and demonstrate ongoing competency. Licensed Practical Nurses may only perform those functions for which they have documented knowledge, skills, and abilities under appropriate supervision. A review of the facility policy entitled Administration of Medication or Flush Through Central Venous Line last reviewed January 1, 2026, reveals the procedure guideline assumes the licensed nurse has the nursing education and skills to perform the task. The policy statement indicated administration of medication or flush through a central venous line is a complex procedure that requires necessary education, training, and experience. A clinical record review revealed Resident 1 was admitted on [DATE], with a PICC line (a long, thin catheter inserted into a vein and advanced to a large vein near the heart to deliver medications, fluids, or nutrition over time) for antibiotic administration. Physician orders required routine flushing of the PICC line with 10 milliliters (ml) of normal saline (a sterile saltwater solution used to maintain catheter patency and prevent blockage). A review of the February 2026 electronic Medication Administration Record (eMAR, the legal record used to document medication administration) showed Employee 7 Licensed Practical Nurse (LPN) and Employee 8 (LPN) documented multiple instances of accessing the PICC line to administer normal saline flushes. Employee 7 Licensed Practical Nurse (LPN) documented administering a normal saline flush through the PICC line on the following dates and times: February 7, 2026, at 12:09 AMFebruary 12, 2026, at 7:07 PMFebruary 19, 2026, at 5:58 PMFebruary 19, 2026, at 11:26 PMFebruary 20, 2026, at 3:34 PMFebruary 20, 2026, at 11:52 PM Employee 8 LPN documented administering a normal saline flush through the PICC line on the following dates and times: February 6, 2026, at 12:04 AMFebruary 12, 2026, at 1:02 AM A clinical record review revealed Resident 30 was admitted on [DATE], with a PICC line for antibiotic therapy related to chronic multifocal osteomyelitis (a bone infection affecting multiple areas). A review of physician orders dated March 3, 2026, required the PICC line to be flushed with 10 milliliters (mL) of normal saline before and after medication administration and during the day and evening shift.Physician orders required routine flushing of the PICC line and administration of intravenous antibiotics. The March 2026 eMAR indicated Employee 7 (LPN) accessed the PICC line to administer flushes and intravenous antibiotics, including Ampicillin Sodium and Ceftriaxone Sodium (antibiotic medications used to treat bacterial infections). Employee 7 (LPN) documented administering a normal saline flush through the PICC line on the following dates and times: March 3, 2026, at 9:07 PMMarch 27, 2026, at 11:32 PM Further clinical review revealed Employee 7 (LPN) documented administering Ampicillin Sodium (medicine that helps fight bacteria) 2 grams (gm) through the PICC line on March 3, 2026, at 9:56 PM and Ceftriaxone Sodium 2gm (medicine that helps fight bacteria) on March 3, 2026, at 8:54 PM. A review of employee personnel records revealed: Employee 7, LPN, employed through a contracted agency beginning April 5, 2025, had no documented education, training, or competency validation (process used to confirm a staff member can safely and (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	correctly perform a task) related to PICC line management.Employee 8, LPN, employed through a contracted agency beginning December 16, 2025, had no documented education, training, or competency validation related to PICC line management.There was no evidence that the facility or contracted agency provided a structured training program, competency validation or ongoing education specific to PICC line care for licensed nursing staff.During an interview on April 24, 2026, at 9:40 AM, the Regional Administrator of Clinical Operations confirmed the facility could not provide documentation of PICC line-specific training or competency validation and confirmed the facility had not developed or implemented a training program specific to PICC line management for agency licensed nurses. Pennsylvania State Board of Nursing regulations (Title 49, Chapter 21) require Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) performing intravenous therapy, which includes administration of medications and care involving PICC lines, to complete a board-approved education program, receive supervised clinical instruction, and undergo ongoing competency assessments. LPNs may perform only those intravenous therapy functions for which they have documented knowledge, skills, and abilities under appropriate supervision. The facility failed to develop, implement, and maintain an effective training program based on its facility assessment to ensure licensed nursing staff possessed the knowledge and competencies necessary to safely provide care to residents requiring PICC line management. 28 Pa. Code 201.20(a) Staff Development. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services.