| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395335 | A. Building<br>B. Wing | 04/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| William Penn Nursing and Rehab | 163 Summit Drive<br>Lewistown, PA 17044 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure a medication error rate of less than five percent (Residents 63 and 79).Findings include:The facility's medication error rate was 12 percent based on 25 medication opportunities with three medication errors.Observation on April 17, 2026, of Resident 79's medication administration at 8:28 AM revealed that Employee 3, licensed practical nurse, administered one 20 mg (milligram) tablet of Lasix (a diuretic medication used to treat fluid retention). Clinical record review for Resident 79 revealed a physician order dated April 6, 2026, stating, Furosemide 20 MG Tablet TAKE THREE TABLETS (60MG) BY MOUTH ONCE DAILY RELATED TO EDEMA, UNSPECIFIED. Concurrent observation of Resident 79's medication administration revealed that Employee 3 administered two tablets of Potassium Chloride Crys ER (Extended Release) Oral 20 MEQ (milliequivalent), and broke both tablets in half prior to administration. The medication reference Drugs.com (a comprehensive and widely visited website that provides free, peer-reviewed, accurate, and independent drug information) instructions regarding the administration of Potassium Chloride noted, Do not crush, chew, break, or suck on an extended-release tablet or capsule. Interview with Employee 3 on April 17, 2026, at 8:50 AM confirmed that the medication card for Resident 79 contained Furosemide 20 MG Tablets, and the employee administered only a single pill. The above information regarding Resident 79 was reviewed with the Director of Nursing on April 17, 2026, at 11:00 AM Review of Resident 63's current physician orders revealed an order dated September 3, 2025, for Tamsulosin HCL (a medication that is used to improve urine flow); give 0.8 milligrams (mg) by mouth one time a day related to anuria (the body fails to produce urine or there is a blockage in the urinary tract preventing proper urine flow) and oliguria (reduction of urine production); give within 30 minutes of breakfast; do not crush, chew, or open. The order indicated that the pharmacy supply was dispensed and received on March 19, 2026, and the medication on hand was Tamsulosin HCl 0.4 mg capsules; take two capsules (0.8 mg) by mouth once daily related to anuria and oliguria. Observation of Resident 63's medication administration pass on April 17, 2026, at 8:27 AM revealed that Employee 6, licensed practical nurse (LPN), prepared the medications prior to administration. This preparation included one Tamsulosin 0.4 mg capsule. Employee 6 then proceeded to administer the medication to Resident 63. An interview with Employee 6 on April 17, 2026, at 9:47 AM revealed that the LPN administered only one capsule of the Tamsulosin and Resident 63 should have received two capsules for a total dose of 0.8 mg per the physician order. The above information for Resident 63 was reviewed with the Director of Nursing on April 17, 2026, at 9:55 AM. Review of Resident 63's medication supply card with the Director of Nursing at the medication cart on April 17, 2026, at 10:00 AM revealed the supply was Tamsulosin 0.4 mg capsules and the directions noted to administer two capsules for a total dose of 0.8 mg. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services |

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

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the facility's main kitchen. Findings include: Initial tour of the facility's main kitchen with Employee 1, dietitian, on April 14, 2026, at 10:12 AM revealed the following: The wall mounted soap dispenser located adjacent to the handwashing sink was coming off the wall. The walk-in freezer contained a box of bagged broccoli cuts and lima beans that were open to the ambient air. The spice rack contained the following outdated containers of spices: ground all spice with a use by date of July 19, 2024; rosemary with a written use by date of September 19, 2024; thyme with a use by date of March 6, 2025. The dry goods storage area contained a container of whole bay leaves with a written use by date of December 20, 2024. There was a bent adaptive piece of silverware in a drawer on the table that held the coffee machine. The piece of silverware had a discolored piece of scotch tape on the handle. Employee 1 reported the adaptive silverware is not used anymore. The dishwasher room contained the following: The ceiling contained areas of black, gritty discoloration. There was a printed paper sign in a plastic protective covering on top of the dishwasher that noted, Dish room rules. The paper sign was wet and discolored and there was moisture build-up inside of the plastic protective covering. There were personal protective gowns for staff hanging on the wall that had a build-up of stains. There were three observed winged insects on the gowns. There were cobwebs under the stainless-steel table along the wall. There were cobwebs on a pipe going into the ceiling next to the ice machine. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 14, 2026, at 11:02 AM. 28 Pa. Code 201.14(a) Responsibility of licensee |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on review of select facility policies and procedures, observation, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate transmission-based precautions (TBP) for two of three residents reviewed on TBP (Residents 127 and 129).Findings include: The facility policy entitled Transmission-Based (Isolation) Precautions, last reviewed without changes on March 19, 2026, revealed it is the facility policy to take appropriate precautions to prevent transmission of pathogens, based on pathogens' modes of transmission. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident, or the resident's environment. Facility staff will apply transmission-based precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. The category of transmission-based precautions will determine the type of personal protective equipment (PPE) to be used. Contact precautions are intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or resident's environment. Healthcare personnel caring for residents on contact precautions are to wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning and doffing PPE up on entry into the resident's environment and discarding before exiting the room is done to contain pathogens. Clinical record review revealed the facility admitted Resident 127 on April 5, 2025. A physician order dated April 5, 2026, revealed staff were to initiate contact precautions for Resident 127 for VRE (vancomycin resistant enterococci, a type of bacteria resistant to the antibiotic vancomycin) in her foot wound. Observation of Resident 127's room on April 14, 2026, at 10:29 AM revealed there was a three-drawer bin with gowns in it, outside of Resident 127's room. There were no gloves. Observation of a sign on Resident 127's door revealed she was on contact precautions, and everyone must put gloves and a gown on before entry, and discard gloves and gown before exiting Resident 127's room. Observation of Resident 127's room on April 14, 2026, at 1:58 PM revealed Employee 5 (licensed practical nurse) entered Resident 127's room. Employee 5 did not put a gown or gloves on at any point while in the room. Upon exiting the room, the surveyor questioned Employee 5 and he stated that he was getting vitals. Observation of Resident 127's room on April 15, 2026, from 9:22 AM to 9:38 AM revealed Employee 7 (nurse aide) provided morning care to Resident 127's roommate in the residents shared bathroom. Employee 7 did not put a gown or gloves on at any point while in Resident 127's room. Interview with Employee 7 confirmed that Resident 127 can utilize the bathroom. Observation of Resident 127's room on April 15, 2026, at 9:58 AM revealed Employee 8 (nurse aide) was at Resident 127's bedside, getting Resident 127's lunch order. Employee 8 did not put a gown or gloves on at any point while in Resident 127's room. The facility failed to implement appropriate contact precautions for Resident 127. The above findings for Resident 127 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on April 15, 2026, at 2:07 PM. Clinical record review for Resident 129 revealed a diagnosis of Enterocolitis due to Clostridium Difficile (inflammation of the intestines due to a bacterial infection, also referred to as C. difficile). Further review revealed the resident was on Transmission-Based Precautions (additional infection control measured used to prevent the spread of infectious diseases, also referred to as TBP). According to the Centers for Disease Control and Prevention (CDC), strict adherence to glove use is the most effective means of preventing hand contamination with C. difficile spores as these spores are not killed by ABHR (alcohol-based hand rubs) and may be difficult to remove even with thorough hand washing. Contamination of high touch environmental surfaces (e.g., bedside table, bed rails, toilets, sinks, and handrails), contributes to transmission of pathogens including C. difficile. C. difficile spores can live on inanimate surfaces for up to 5 months. Observation of Resident 129's room on April 15, 2026, at 10:05 AM revealed the appropriate TBP items, including gloves and cloth gowns, located<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | outside of the resident's room. Upon exiting the resident's room and removing the TBP items, there were two bins located at the doorway, one for the contaminated soiled gowns/laundry, and one for contaminated disposable gloves/refuse. Both bins were noted to have a lid in place and required the user to use their hand to access the bins and dispose of any contaminated items and then replace the lids. Observation of Resident 127's room on April 14, 2026, at 10:29 AM, revealed there were two bins located between the window and door beds against the wall, one for contaminated soiled gowns/laundry, and one for contaminated soiled gloves/refuse. Both bins were noted to have a lid in place that required the user to use their clean hand to access the bins and dispose of any contaminated items and then replace the lids. The above concerns regarding Residents 129 and 127 were discussed with the Nursing Home Administrator and the Director of Nursing on April 16, 2026, at 2:30 PM. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 23 residents reviewed (99).Findings include: Clinical record review for Resident 99 revealed a MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 21, 2026, that facility staff assessed Resident 99 as receiving an anticoagulant medication during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 99 received an anticoagulant medication during the assessment period for the MDS noted above.Interview with the Director of Nursing on April 16, 2026, at 2:07 PM confirmed that Resident 99's February 21, 2026, MDS was coded in error regarding receiving an anticoagulant medication. 483.20(g) Accuracy of AssessmentsPreviously cited 5/9/25 28 Pa. Code 211.5(f)(ix) Medical records28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive, person-centered care plan for infection control concerns for two of 23 residents reviewed (Residents 127 and 128).Findings include: Clinical record review revealed the facility admitted Resident 127 on April 5, 2026. A physician order dated April 5, 2026, revealed staff were to initiate contact precautions (measures to prevent the spread of infections transmitted by direct/indirect contact with a resident or their environment) for Resident 127 for VRE (vancomycin resistant enterococci, a type of bacteria resistant to the antibiotic vancomycin) in her foot wound. Further review of Resident 127's clinical record revealed her care plan-initiated April 5, 2026, listed infection of and was blank after. The care plan noted staff were to maintain isolation precautions as indicated but did not specify what. Clinical record revealed the facility admitted Resident 128 on April 5, 2026. A physician order dated April 6, 2026, revealed staff were to initiate contact precautions. Nursing documentation dated April 5, 2026, at 9:49 AM, revealed Resident 128 has a PICC (peripherally inserted central catheter, provides access to the large veins near the heart by inserting a thin flexible tube into a vein the upper arm) in his left upper extremity and MRSA (Methicillin-resistant Staphylococcus aureus, a type of bacteria that causes skin infections and is resistant to many antibiotic) in his blood. Further review of Resident 128's clinical record revealed his care plan-initiated April 5, 2026, noted Resident 128 had infection of sepsis, bacteremia, and pneumonia. The interventions listed were to administer medications per physician orders, obtain labs as ordered and notify physician of results, and obtain vital signs as indicated. Resident 128's plan of care did not address Resident 128 being on contact precautions related to MRSA in his blood. The above findings for Residents 127 and 128 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on April 16, 2026, at 2:11 PM. 28 Pa. Code 211.10. (a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on clinical record review, observation, and staff, it was determined that the facility failed to ensure the highest practical care related to PICC lines (peripherally inserted central catheter, provides access to the large veins near the heart by inserting a thin flexible tube into a vein the upper arm) for two of 23 residents reviewed (Residents 127 and 128). Findings include: Clinical record review revealed the facility admitted Resident 128 on April 5, 2026. Nursing documentation dated April 6, 2026, at 4:48 PM, revealed Resident 128 stated, he wanted a pair knife to cut his line. Documentation revealed Resident 128 then tried to pull at his PICC line. Further review of Resident 128's clinical record revealed a physician order dated April 5, 2026, for staff to maintain an emergency kit for Resident 128's PICC line at his bedside. Observation of Resident 128's room on April 14, 2026, at 1:05 PM revealed there was no emergency kit visible in his room. Further observation on April 15, 2026, at 10:02 AM, revealed a small bag of gauze in his top dresser drawer under his personal items. Clinical record review revealed the facility admitted Resident 127 on April 5, 2026. Further review of Resident 127's clinical record revealed a physician order dated April 5, 2026, for staff to maintain an emergency kit for Resident 127's PICC line at her bedside. Observation of Resident 127's room on April 14, 2026, at 11:55 AM revealed there was no emergency kit visible in her room. Observation of Resident 127's room with the Director of Nursing on April 15, 2026, at 9:36 AM revealed that she was unsure if there was an emergency kit in Resident 127's room. After searching for the emergency kit she was able to find some gauze in Resident 127's dresser drawer mixed in with Resident 127's personal items. Interview and observation of Resident 127's room with Employee 5 (licensed practical nurse) on April 15, 2026, at 11:57 AM revealed the facility usually tapes emergency kits on the wall behind the residents' beds. Employee 5 searched Resident 127's room for three and a half minutes before finding the gauze in Resident 127's drawer with her personal items. The facility failed to ensure accessibility of necessary emergency supplies for Residents 127 and 128 PICC lines. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to ensure the availability of necessary emergency supplies and provide care consistent with professional standards of practice for one of one resident reviewed receiving hemodialysis (Resident 10).Findings include: Clinical record review for Resident 10 revealed a diagnosis list that included the following related to hemodialysis (a machine that performs a basic function of the kidney by cleansing the blood of impurities): end stage renal disease, chronic kidney disease, and an arteriovenous (AV) fistula (surgically created connection between an artery and a vein to provide an access for hemodialysis). Review of the current physician orders for Resident 10 revealed the following: An order dated August 24, 2025, noted, dialysis precautions: no blood draws, injections, or blood pressure from (specify) arm. Emergency kit at bedside containing appropriate equipment; tourniquet, sterile gauze, gloves, etc. Nursing documentation dated August 24, 2025, at 11:23 AM revealed the facility staff received report from the hospital that indicated that Resident 10 receives dialysis and has a catheter in the right chest and an AV fistula in the left arm. Review of Resident 10's care plan revealed that the resident has renal insufficiency related to chronic renal failure and the presence of a fistula/graft/catheter. An intervention dated September 11, 2025, noted Emergency equipment at bedside. Review of a recent dialysis communication worksheet dated April 3, 2026, revealed that the access site for dialysis was noted as the right chest port. Observation of Resident 10's room on April 16, 2026, at 11:18 AM with Employee 4, licensed practical nurse, revealed an emergency kit contained in a mesh bag that was hanging on the wall above the head of the bed. Review of the kit with Employee 4 revealed the kit contained gauze, pressure dressing, and tape. The kit did not contain a tourniquet and gloves as specified in the physician order. Observation of Resident 10's room on April 16, 2026, at 12:08 PM, with the Director of Nursing confirmed that the kit contained gauze, pressure dressing, and tape. A concurrent interview with Resident 10 confirmed the resident received hemodialysis and has both an AV fistula in the left arm and a right chest port for dialysis access. The Director of Nursing further noted that the emergency kit should also contain tubing clamps which were not present. A review of the facility policy titled, Hemodialysis, last reviewed by the facility on March 19, 2026, revealed that the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, and psychosocial needs of residents receiving hemodialysis. The policy did not address an emergency kit and what supplies are to be kept in the kit. A meeting with the Nursing Home Administrator and Director of Nursing on April 16, 2026, at 2:08 PM revealed that the facility would have to contact the medical provider to clarify the order and see exactly what was needed in the emergency kit that is kept at the bedside. Further review of Resident 10's clinical record revealed a physician order dated August 25, 2025, that noted no treatment or blood pressure to the left arm due to AV fistula (arteriovenous fistula). Review of the care plan for Resident 10 revealed that the resident has renal insufficiency related to chronic renal failure and the presence of a fistula/graft/catheter. An intervention dated September 11, 2025, noted, Do NOT take blood pressure or blood specimens from LEFT/RIGHT arm. Review of the Kardex (documentation by nursing to note important information and care planning and facilitate resident care) for Resident 10 revealed a section titled, Safety. This section noted, Do NOT take blood pressure or blood specimens from LEFT/RIGHT arm. Resident 10's care plan and Kardex did not reflect the physician order. It was unclear if the resident had a limb restriction in only the left arm (as indicated by the physician order) or both arms (as indicated by the care plan and Kardex). The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 16, 2026, at 2:08 PM. The Director of Nursing reported the facility would have to clarify the limb restriction. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide recommended pneumococcal immunizations for one of five residents reviewed for immunizations (Resident 3).Findings include: The facility policy entitled Pneumococcal Vaccine, last reviewed without changes revealed March 19, 2026, revealed it is the facility policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be assessed for pneumococcal immunizations upon admission. Each resident will be offered a pneumococcal immunization unless it is contraindicated, or the resident has already been immunized, the type of pneumococcal vaccine (PCV15, PCV20, PCV21, or PPSV23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations. Clinical record review revealed the facility admitted Resident 3 on December 27, 2021. Documentation in Resident 3's clinical record revealed he received two pneumococcal vaccines prior to his admission (Prevnar 13 and Pneumovax 23). Review of Resident 3s pneumococcal consent dated February 20, 2022, revealed Resident 3 refused noting already had it. According to the CDC guidance entitled Pneumococcal Vaccine Timing for Adults dated October 2024, Resident 3's pneumococcal vaccinations would not be completed until he received one dose of Prevnar 20 or Prevnar 21 at least five years after the last pneumococcal vaccine dose. There was no evidence to indicate that the facility offered Resident 3 an updated pneumococcal vaccination. Interview with Employee 2, infection control preventionist, on April 16, 2026, at 9:10 AM confirmed the above findings for Resident 3. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management |