STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395343	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myerstown Nursing and Rehab LLC	7 West Park Avenue Myerstown, PA 17067

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 clinical record review and staff interview, it was determined that the facility failed to follow physician orders for one of five sampled residents. (Resident 1) Findings include:Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure and diabetes. On April 23, 2026, the physician ordered for staff to weigh Resident 1 daily. Review of Resident 1's care plan revealed he was at risk for a nutritional problem with an intervention for staff to weigh the resident at the same time of day and record the weight. Review of Resident 1's weight record revealed no documented evidence that weights were obtained per physician order on April 23, 25, 27, and 28, 2026. In an interview on June 18, 2026, at 12:05 p.m., the Director of Nursing confirmed that there was no documented evidence Resident 1's weights were obtained per physician order. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide treatment, and assess and document the status of wounds for one of five sampled residents. (Resident 1)Findings include: Review of the facility policy entitled, Skin and Wound Management System, revealed that ongoing weekly evaluations of the resident's skin would be completed and documented in the electronic medical record on the Weekly Skin Evaluation form, that wound location and characteristics would be documented in the medical record, and that wound status would be evaluated and documented on the Wound Evaluation Flow Sheet form.Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure and diabetes. Review of the admission Nursing Evaluation dated April 23, 2026, revealed that Resident 1 had pressure ulcers to the right and left heels. On April 23, 2026, the physician ordered for staff to apply skin prep (protective barrier) the Resident 1's left heel every shift and a dry dressing to the right heel daily. On April 30, 2026, the physician ordered for staff to complete a weekly skin check and complete the Weekly Skin Check Form. Review of the care plan revealed Resident 1 had an actual skin impairment with an intervention for staff to monitor and document location, size and treatment of the injury and to provide treatments as ordered. There was no documented evidence that the treatments were completed to Resident 1's left or right heel from April 23 to May 4, 2026. There was no documented evidence that Resident 1's wound was evaluated or his Weekly Skin Check Form completed on April 30, 2026. In an interview on June 18, 2026, at 12:04 p.m., the Director of Nursing confirmed that there was no documented evidence that Resident 1's treatments to his left and right heels were completed per physician order. 28 Pa Code 211.12 (d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395343	A. Building B. Wing	06/18/2026

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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 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 facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement appropriate measures for the care and management of a peripherally inserted central catheter (PICC) (thin, flexible tube inserted into a vein that allows healthcare providers to deliver medications, fluids, blood products, or nutrition directly into the bloodstream over an extended period) in accordance with facility policy and physician's orders for one of five sampled residents. (Resident 2)Findings include: Review of the facility policy entitled, Catheter Insertion and Care - Midline Dressing Changes, revealed that catheter dressings would be changed at specific intervals, or when needed. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis (infection). Review of Resident 2's care plan revealed Resident 2 had a PICC line with an intervention for staff to change the dressing as ordered by the physician. On May 28, 2026, the physician ordered for staff to change the transparent dressing on admission and then weekly. Observations on June 18, 2026, at 11:08 a.m., revealed Resident 2's dressing to be clean, dry, and intact. In an interview at that time, Resident 2 stated it had not been changed yet. Review of Resident 2's Treatment Administration Records revealed no documented evidence that the dressing was changed on June 10 or 17, 2026. In an interview on June 18, 2026, at 12:44 p.m., the Director of Nursing confirmed that there was no documented evidence that Resident 2's dressing was changed as ordered by the physician. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.