

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Myerstown Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on facility policy review, clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to report allegations of abuse to the State Survey Agency for two of eight sampled residents. (Residents 1 and 2) Findings Include: Review of the facility policy entitled, Abuse Policy, last reviewed July 8, 2026, revealed that immediately upon receiving information concerning a report of suspected or alleged abuse, the Administrator or designee would report allegations that involved abuse not later than two hours after the allegation was made and report allegations to the appropriate state and local authorities within 24 hours if the event did not result in serious bodily injury. Clinical record review revealed that Resident 2 had diagnoses that included chronic kidney disease, heart disease, type 2 diabetes, and dementia. Review of facility documentation revealed that on July 16, 2026, Resident 8 entered the room Resident 2 shares with Resident 1 and kissed her without her consent. Clinical record review revealed that Resident 1 had diagnoses that included type 2 diabetes, heart disease, spinal damage, and post-traumatic stress disorder (PTSD). Review of facility documentation revealed that on July 16, 2026, another resident (Resident 8) threatened Resident 1 with violence when he intervened as Resident 8 kissed Resident 2 without her consent. Review of facility documentation dated July 16, 2026, revealed that the facility was made aware of the alleged violations of abuse involving Residents 1, 2, and 8 on July 16, 2026. There was a lack of evidence that the facility reported the alleged incident and violations to the State Survey Agency as of July 28, 2026. In an interview on July 27, 2026, at 1:45 p.m., the Director of Nursing confirmed that no report had been filed with the State Survey Agency. 28 Pa. Code 201.14(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to monitor and prevent behavioral symptoms for one of eight sampled residents. (Resident 8) Findings included: Clinical record review revealed that Resident 8 had diagnoses that included dementia with agitation, Alzheimer's disease, and colon and prostate cancer. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was cognitively impaired. A physician's order dated February 18, 2026, directed staff to monitor and document agitated behaviors along with non-pharmacological interventions attempted every day and on every shift. Review of Resident 8's care plan initiated on February 18, 2026, included interventions for dementia that included engaging the resident in structured activities and to observe, document, and report behavioral changes to the physician. Review of facility documentation revealed that on February 9, 2026, Resident 8 was admitted to the hospital after choking his wife at home. He was transferred to the facility on February 18, 2026. On April 26, 2026, Resident 8 had misidentified a female resident as his wife, attempted to kiss her, and followed her while demanding her attention until staff intervened, resulting in his move to a different floor within the facility. On July 16, 2026, Resident 8 entered a room occupied by a married resident couple, Residents 1 and 2, without invitation. Resident 8 allegedly kissed or attempted to kiss Resident 2 without her consent. When Resident 1 objected, Resident 8 threatened him with bodily harm. Review of facility documentation from June 27, 2026, through July 27, 2026, revealed a lack of evidence that Resident 8's behavior was monitored and documented for 22 of 30 days, including July 16, 2026. During observations on July 27, 2026, between 10 a.m., and 3:30 p.m., no staff were observed supervising, monitoring, or involving Resident 8 in an activity. Resident 8 was observed unsupervised interacting with other residents, walking the halls independently, and sitting at a window alone. In an interview on July 27, 2026, at 3:42 p.m., the Director of Nursing confirmed that the resident's physician's orders and care plan were not implemented to provide behavioral health management. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		