

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

Printed: 10/09/2026
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 07/15/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on policy review, observation, and staff interview, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department. Findings include: Review of the facility's policy entitled, General Food Preparation and Handling, dated July 18, 2025, revealed that when foods were received, staff were to check and store them as soon as they were delivered and that staff were to date leftover food items. Observations during the tour of the dietary department on July 12, 2026, at 10:06 a.m., revealed the following: In the dry storage room, there were two insects flying around the food area. There was an opened large shipment box of chocolate brownie mix directly touching the floor that contained four smaller boxes that were not stocked in the food storage area. There was a box of bananas directly touching the floor. There were two large juice shipment boxes directly touching the floor. One of the boxes was opened and had six smaller juice cartons left in the box that were not stocked in the food storage area. On a set of shelves, there was a box of buttermilk pancake mix with a use by July 6, 2025. On the floor in front of the shelves that stored sugar packets, there was a large area of a granular white substance with a shoe print in it. Across from the shelves, there was an area of dried white splatter on the floor. In cooler 2, there were multiple areas with food debris on the floor including onion skins, mashed peas, a crushed margarine cup, a dried brown celery stalk, and an apple. On a shelf, there was a cut onion labelled use-by June 21, 2026. There were two stacks of food boxes directly touching the floor. There was an opened bag of shredded carrots that was not dated. There was a shelf that had seven cups of yogurt with a use by date of July 4, 2026, and one large yogurt container with a use by date of June 29, 2026. There were two small bags each of shredded carrots and cabbage that were both mushy when touched and not dated. There was an opened bag of salad mix with brown lettuce and mushy carrots that was dated June 6, 2026. There was a large pan of peeled potatoes in water that was labelled use-by July 5, 2026, and had a very strong odor to it. In cooler 3, on the floor, there was an area of black dried liquid next to two crushed coffee creamers. On a shelf, there were three opened gallons of milk, two bottles were labelled use-by July 10, 2026, and one was labelled use-by July 8, 2026. There were two stacks of milk crates containing milk directly touching the floor. There were two areas of a solid, brown, thick, substance coming out from the ceiling above the middle fan that was running. In the walk-in freezer, there were four boxes of frozen food directly touching the floor. There were green peas on the floor. The freezer fan was covered with a layer of thick ice. Below it, there was a large accumulation of ice, next to a frozen box of chicken patties. At the coffee station, there was a dried white substance on the ground in front of the sink. There were two areas of dried brown liquid under the drain on the shelf and behind the drainpipe. There was an uncovered garbage can, the lid was stored under the can, with an insect flying around it. There were no staff working in that area at that time. In tray line cooler 18370, there was an uncovered pan of gravy with the utensil (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395343
		If continuation sheet Page 1 of 13

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	still in it. In tray line cooler 15883, there were four cups of dished peaches and one cup of dished chocolate pudding, not covered and dated. In the dish machine room, on top of the dish machine, by the temperature gages, there were several small piles of brown crumbled debris. In an interview on July 13, 2026, at 10:45 a.m., the Dietary Director confirmed the previously mentioned items should have been dated, the expired items should have been removed and were not, and that the last food delivery was on July 10, 2026. CFR 483.60(i) Food Safety Requirement Previously cited 8/21/2528 Pa. Code 201.14(a) Responsibility of licensee.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation and staff interview, it was determined that the facility failed to ensure that a safe, clean, and comfortable environment was maintained on one of four nursing units. (Third Floor) Findings include: Observations in the facility from July 13, 2026, at 11:15 a.m., through July 15, 2026, at 1:00 p.m., revealed the following: There were areas of dirty dried splatter and trash on the floors throughout four of four hallways. The handrails in four of four hallways were sticky and had an unpleasant odor. There was trash and a sticky substance on the floors in resident rooms [ROOM NUMBER]. The trash can was overflowing and dirty laundry was piled beneath the sink in resident room [ROOM NUMBER]. The plastic trim on front of the sink in room [ROOM NUMBER] was on the floor. A metal panel from the heater in the shower room was on the floor and a white substance was on the thermometer hanging in the shower stall. An orange substance was on the bottom of the refrigerator in the medication storage room. CFR 483.10(i) Safe Environment Previously cited 8/21/25, 1/23/26. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(2.1) Management.		

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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. Based on clinical record review and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for two of 20 sampled residents. (Residents 1 and 74) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included acute and chronic respiratory failure and congestive heart failure. A physician's order dated July 3, 2026, directed staff to administer a blood pressure medication (metoprolol) two times daily. The physician ordered that staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was lower than 110 millimeters of mercury (mm/Hg) or if Resident 1's heart rate was less than 60 beats per minute (bpm). Review of Resident 1's Medication Administration Record (MAR) for July of 2026, revealed that staff administered metoprolol seven times when Resident's 1's SBP was lower than 110mm/Hg. The metoprolol was withheld once when Resident 1's SBP was greater than 110mm/Hg and heart rate was greater than 60 bpm. Clinical record review revealed that Resident 74 had diagnoses that included type 2 diabetes, heart disease, and chronic constipation. A physician's order dated January 15, 2026, directed staff to administer 17 grams of MiraLax Powder, once daily as needed for constipation. A physician's order dated March 29, 2025, directed staff to administer four ounces of prune juice on the second day without a bowel movement. A physician's order dated March 29, 2025, directed staff to administer 30 ml of Magnesium Hydroxide Suspension once daily for constipation on the third day with a small or no bowel movement. Review of Resident 74's clinical record revealed no evidence that Resident 74 had no bowel movements from June 15 through 21, and June 24 through 28, 2026. There was a lack of documentation to support that physician's orders for constipation were implemented. In an interview on July 15, 2026, at 11:10 a.m., the Director of Nursing confirmed that the residents' physician's orders were not followed. CFR 483.25 Quality of care Previously cited 6/18/26 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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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 four sampled residents with pressure ulcers. (Resident 7) Findings include: Review of the facility policy entitled, Skin and Wound Management System, last reviewed July 18, 2026, revealed that ongoing weekly evaluations of the resident's skin would be completed and documented in the electronic medical record and if there were identified skin impairments, the wound location, characteristics, and wound status would be evaluated and documented in the resident's medical record. Clinical record review revealed that Resident 7 was admitted to the facility on [DATE], with diagnoses that included severe malnutrition and dementia (a severe, progressive decline in cognitive abilities that affect a person's ability to function). The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired, was dependent on staff for activities of daily living, and was at risk of developing pressure ulcers. Review of the care plan revealed that Resident 7 was at risk for skin breakdown and had a pressure ulcer on the right hip. A physician's order dated June 29, 2026, directed staff to cleanse Resident 7's left heel with normal saline solution, apply betadine to the base of the wound, and leave open to air twice a day on day shift (7:00 a.m. to 3:00 p.m.) and evening shift (3:00 p.m. to 11:00 p.m.), and as needed for deep tissue injury (a type of wound caused by intense or prolonged pressure and shear). There was no documented evidence that the wound location, characteristics, and wound status were evaluated weekly during the week of July 6, 2026. Review of the Treatment Administration Record (TAR) for July 2026, revealed no evidence that staff completed the wound treatment as ordered on the day shift on July 13, 2026. In an interview on July 15, 2026, at 2:50 p.m., the Director of Nursing confirmed that there was no documented evidence that Resident 7's left heel pressure ulcer was assessed weekly or that the treatment to his left foot was completed on the previously mentioned dates. 28 Pa Code 211.12 (d)(1)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined the facility failed to implement safety interventions for one of 20 sampled residents. (Resident 34) Findings include: Clinical record review revealed that Resident 34 had diagnoses that included arthritis of the left knee and difficulty walking. The Minimum Data Set assessment dated [DATE], revealed that Resident 34 required assistance for transfers from one surface to another. Review of the care plan revealed that the resident had a history of falls and staff were instructed to place fall mats on both sides of the bed. Observations on July 12, 2026, at 11:32 a.m. and 2:10 p.m. and July 14, 2026, at 11:26 a.m. and 1:30 p.m., revealed that Resident 34 was in bed without the floor mats in place on either side of the bed. In an interview on July 15, 2026, at 10:52 a.m., the Director of Nursing confirmed that the floor mats should have been in place. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide adequate respiratory care for two of 20 sampled residents. (Residents 1 and 74) Findings include: Review of the facility policy entitled, O2 Safe Solutions, Equipment Changing, last reviewed July 18, 2025, revealed that all equipment, including nasal cannulas, humidifiers, and oxygen tubing, should be changed weekly, and marked with the date it was changed. Clinical record review revealed that Resident 1 had diagnoses that included acute and chronic respiratory failure and congestive heart failure. On June 13, 2026, The physician ordered staff to administer oxygen via a nasal cannula every day on all three shifts. The order also instructed staff to change the oxygen tubing and humidification bottle, clean the oxygen filter, and date the tubing on the oxygen concentrator in Resident 1's room every Saturday night. On July 12, 2026, at 10:49 a.m., Resident 1 was observed in a wheelchair in the third floor dining room with the cannula beneath his chin and connected to an empty oxygen tank. On July 12, 2026, at 1:23 p.m., Resident 1 was observed sitting on the bed wearing a nasal cannula with undated tubing that was not connected to the running oxygen concentrator. Resident 1 stated at that time that he was not aware of when the tubing was replaced. Clinical record review revealed that Resident 74 had diagnoses that included type 2 diabetes, heart disease, and chronic constipation. A physician's order dated May 17, 2026, instructed staff to administer oxygen at night for shortness of breath. A physician's order dated May 17, 2026, instructed staff to change the oxygen tubing and humidification bottle, clean the oxygen filter, and date the tubing every Sunday night. Observations on July 12, 2026, at 11:16 a.m., and July 13, 2026, at 1:21 p.m., revealed the oxygen tubing for Resident 74 was not dated and the filter on the concentrator was covered with a white substance. During interviews at those times, Resident 74 stated that he did not know when the tubing was last replaced, but was sure it had been more than two weeks. In an interview on July 15, 2026, at 11:10 a.m., the Director of Nursing confirmed that the resident's oxygen equipment had not been maintained per policy and physician's orders. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one sampled resident receiving dialysis (process of removing excess toxins and water from the blood). (Resident 2) Findings include: A review of the facility policy entitled, Care Planning Special Needs - Dialysis, last reviewed July 18, 2025, revealed that nursing staff were to provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day and as needed. Clinical record review revealed that Resident 2 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis and had a physician's order for the resident to receive dialysis three days per week. There was no evidence in the clinical record or the pre-dialysis communication forms that staff obtained and/or provided Resident 2's vital signs, recorded the resident's condition, or noted treatments provided on the day of dialysis treatment to the dialysis provider for 25 of 25 occasions from May 6, 2026, through July 14, 2026. In an interview on July 15, 2026, at 1:12 p.m., the Director of Nursing confirmed that there was no evidence to support that the facility communicated the resident's condition or treatments to the dialysis center on each dialysis treatment day. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, observation, and staff interview, it was determined that the facility failed to serve food in a form prescribed to meet the needs of one of 20 sampled residents. (Resident 8) Findings include: Review of the facility's weekly menu revealed that the lunch meal for a mechanical soft diet texture (modified diet for people who have difficulty chewing and swallowing) on July 13, 2026, was ground chicken tenders, mashed potatoes, and broccoli. Clinical record review revealed that Resident 8 had a diagnoses that included malignant neoplasm of upper lobe, right bronchus, or lung (cancerous tumor that has formed in the upper part of the lung or in the main airway that leads into it) and dysphagia (difficulty in swallowing). A physician order dated August 23, 2025, instructed staff to provide a mechanical soft texture diet. Review of the Speech Therapy Discharge summary dated [DATE], revealed that Resident 8 still needed the mechanical soft ground texture diet. The care plan indicated that the resident had a potential problem for oral and dental problems related to edentulous (no teeth) status and he did not use dentures. The resident was also at risk for nutritional problems due to gradual down trend in weights. There was an intervention for staff to provide and serve the resident with the diet as ordered. During lunch observation on July 13, 2026, at 12:45 p.m., Resident 8 was observed in his chair next to his bed, with his meal tray on his tray table in front of him. Resident 8 was served chicken tenders and French fries that were cut into about one inch pieces and creamy coleslaw. Review of the resident's meal ticket observed at that time revealed he was to receive a mechanical soft diet. In an interview on July 15, 2026, at 11:26 a.m., the Dietary Director stated that the staff were to follow the lunch menu for the mechanical soft diet and Resident 8 should not have received the chopped food items and coleslaw. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b) Management.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident and staff interview, it was determined that the facility failed to accommodate food preferences for one of 20 sampled residents. (Resident 8) Findings include: Clinical record review revealed that Resident 8 had diagnoses that included malignant neoplasm of upper lobe, bronchus or lung (cancerous tumor that has formed in the upper part of the lung or in the main airway that leads into it), chronic obstructive pulmonary disease, and moderate protein-calorie malnutrition. The Minimum Data Set assessment dated [DATE], indicated that resident was alert and oriented and required set up assistance only from staff with activities of daily living. Review of the current care plan identified the resident was at nutritional risk due to a gradual down trend in weight. There was an intervention for staff to provide and serve the diet as ordered. A Nutrition Risk Assessment completed on May 10, 2026, revealed the dietitian noted that Resident 8 was at nutritional risk due to their current disease state with an intervention to serve ice cream with lunch. Observation on July 15, 2026, at 12:45 p.m., revealed that the resident was sitting in a chair next to his bed with his lunch tray on his tray table stand. The main entree, side dish, fruit, and vegetable with a drink was on his meal tray. Staff had served his meal to him. Review of his tray card indicated he was to get ice cream at lunch. In an interview at this time, the resident stated that he did not get ice cream and that he was supposed to and would like to have it. In an interview on July 15, 2026, at 11:08 a.m., the Administrator stated that the dietary department did not follow Resident 8's food preferences identified on the meal ticket. CFR 483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences Previously cited 8/21/25 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b) Management.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 20 sampled residents. (Resident 11) Findings include: Review of the facility policy entitled, Infection Prevention and Control and Procedure Manual, last reviewed July 18, 2025, revealed that enhanced barrier precautions applied when a resident had a wound and that gloves and a gown were to be applied prior to performing high contact care activities including wound care. Clinical record review revealed that Resident 11 had diagnoses that include quadriplegia (the partial or total loss of sensory and motor function in both arms and legs), reduced mobility, and need for assistance with personal care. A pressure injury assessment dated [DATE], revealed that Resident 11 had a stage three pressure injury (a deep, crater-like wound where skin is completely lost, exposing underlying fatty tissue) on the sacrum (the large bone at the base of the spine and the center of the pelvis). A physician's order dated June 9, 2026, directed staff to cleanse the area with normal saline solution, apply a thin layer of Triad paste (a zinc-based paste designed for managing wounds and protecting broken or macerated skin), and cover with bordered gauze dressing daily and as needed. During an observation of wound care on July 13, 2026, at 12:15 p.m., the registered nurse (RN 1) performed a dressing change to Resident 11's sacral pressure injury and did not wear a gown during the high contact care per facility policy. On July 13, 2026, at 2:00 p.m., the Infection Preventionist confirmed that the nurse should have worn a gown during the dressing change. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview, it was determined that the facility failed to post accurate and current nurse staffing information. Findings include: During a tour of the facility conducted on July 12, 2026, at 9:15 a.m., no staffing information was posted. During a tour of the facility conducted on July 13, 2026, at 9:15 a.m., no staffing information was posted. During a tour of the facility conducted on July 15 2026, at 11:50 a.m., the staffing information posted in the lobby was dated July 13, 2026. In an interview on July 15 2026, at 11:50 a.m., the Administrator confirmed that incorrect staffing data was posted on July 15, 2026. 28 Pa Code 201.18(b)(3) Management.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined the facility failed to notify the resident's representative(s) of transfer(s), including the reasons for the moves in writing upon transfer, for one of five residents who were transferred out of the facility. (Resident 10) Additionally, it was determined that the facility failed to provide copies of written discharge or transfer notices to a representative of the Office of the State Long Term Care Ombudsman for four of five sampled residents who were transferred out of the facility. (Residents 7, 9, 12, and 87) Findings include: Clinical record review revealed that Resident 10 was transferred to the hospital on June 19, 2026, after a change in condition. There was no documented evidence to support that the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital. Clinical record review revealed that Resident 7 was transferred to the hospital on April 23, 2026, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 9 was transferred to the hospital on May 22, 2026, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 12 was transferred to the hospital on March 4, 2026, and April 21, 2026, after changes in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 87 was transferred to the hospital on May 4, 2026, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. In interviews on July 14, 2026, at 12:30 p.m., and July 15, 2026, at 11:20 a.m. the Administrator confirmed that there was no documented evidence that the notification of transfer was sent to Resident 10 and their resident representative and that the written copies of the discharge or transfer notices were not sent to the Office of the State Long Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.		