STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395344	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Greenwood Hill	420 Pulaski Drive Pottsville, PA 17901

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of closed clinical records, select facility policy, documentation provided by the facility, and staff interviews, it was determined the facility displayed past non-compliance by failing to protect one out of four residents sampled (Resident 117) from neglect by not ensuring required vehicle safety devices were in place during transportation, resulting in actual harm in the form of a laceration requiring staples. Findings include: A review of the facility policy titled Vulnerable Adult Abuse and Neglect Prevention, last reviewed by the facility June 19, 2025, revealed it is the facility policy to provide professional care and services in an environment that is free from any type of neglect. The policy defines neglect as (a) the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (b) the failure or omission by a caregiver to supply a vulnerable adult with care or services, including, but not limited to, food, clothing, shelter, healthcare, or supervision, which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety. A clinical record review revealed Resident 117 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (a condition where the spinal canal narrows, compressing the nerves in the lower back, leading to pain, numbness, tingling, or weakness in the legs). A care plan initiated May 24, 2025, documented that Resident 117 had limited physical mobility related to weakness, used a four-wheel wheelchair for locomotion (movement from place to place), and required assistance with transportation. A progress note dated July 11, 2025, at 11:31 AM documented the facility was notified that Resident 117 had fallen in the facility transport van and was taken by emergency medical services to the community emergency department for evaluation and treatment. A witness statement from Employee 3, Vehicle Transport Driver, dated July 11, 2025, revealed that while accelerating from a traffic light, she heard a bang and observed that Resident 117's wheelchair had tipped over. Upon stopping the vehicle, Employee 3 observed bleeding from the resident's head and called 911. Employee 3 used items from the first aid kit to hold pressure on the resident's wound. Emergency medical services responded and took the resident to the emergency department. Employee 3 described that she didn't have Resident 117's lap seat belt restraints on the resident during transport. A review of the community emergency department trauma note dated July 11, 2025, at 11:25 AM, revealed documentation that Resident 117's wheelchair had been improperly secured. When the transport van began moving forward, the wheelchair rolled backward, causing the resident's head to strike the van door/wall. The note indicated the resident did not fall out of the wheelchair. The resident reported having a headache but denied syncope (loss of consciousness) or vomiting. The resident stated he reached out with his right hand to brace himself, injuring the hand and reporting pain around the knuckles. The note documented no other injuries or complaints, and no pain involving the neck, chest, abdomen, or long bones (the major bones of the arms and legs). Examination findings included a 1.0 cm occipital scalp laceration (a cut at the back of the head) without active bleeding, with small, localized swelling in the area. The cervical spine (the vertebrae in the neck that supports the head) was examined and cleared using advanced imaging (diagnostic tests such as CT scans or X-rays), showing no cervical spine tenderness. The cervical spine collar (a medical device used to support and stabilize the neck and upper spine to limit movement after injury or surgery) was removed. The scalp laceration measuring 1.0 cm was closed with two staples. The note documented that the resident tolerated the procedure well without immediate complications. Upon return to the facility at 3:30 PM the same day, via stretcher with two emergency medical service personnel. The resident was noted to have a 1.0 cm x 0.1 cm scalp laceration with two staples and an abrasion (scrape or superficial skin injury) to the left scapula (shoulder blade) measuring 2.5 cm x 1.5 cm. No other skin alterations were noted. The resident had complaints of pain at the base of his head at a level of three out of ten (pain scale rating with 0 being no pain and 10 being the worst pain). A new order was noted for Bacitracin (an antibiotic ointment) twice daily for five days and leaving the area open to air. The physician was notified and in agreement. A physician's order for Resident 117 to cleanse the area with staples on the back of the head with soap and water, pat dry, and apply Bacitracin (an antibiotic ointment) and open to air twice a day was initiated on July 12, 2025, at 7:00 AM. A review of Resident 117's medication administration record (MAR) dated July 2025 revealed he received acetaminophen 650 mg on July 12, 2025, at 6:49 AM for pain level three out of ten. The MAR dated July 2025 also indicated the resident's wound was cleansed and treated with bacitracin as ordered by the physician. A progress note dated July 12, 2025, at 2:50 PM documented that Resident 117's neurological

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-initiated transfer notices, and staff interviews, it was determined the facility failed to notify the resident and the resident's representative(s) of a facility initiated transfer in writing and in a language and manner they understand for five out of 28 residents reviewed (Residents 3, 5, 81, 99, and 117). Findings include: A clinical record review revealed Resident 99 was admitted to the facility on [DATE]. Further review showed Resident 99 was transferred to a community hospital on April 2, 2025, and readmitted on [DATE]. A review of the facility-initiated transfer notification form dated April 2, 2025, revealed the facility did not notify the resident or resident representative of the specific reason for the transfer in writing.A clinical record review revealed Resident 3 was admitted on [DATE]. The resident was transferred to a community hospital on April 26, 2025, and readmitted on [DATE]. The transfer notification form dated April 26, 2025, did not indicate the specific reason for the transfer, nor did it provide written information in a manner the resident or representative could understand. A clinical record review revealed Resident 5 was admitted on [DATE]. The resident was transferred to a community hospital on May 1, 2025, and readmitted on [DATE]. The transfer notification form dated May 1, 2025, did not include a written statement of the specific reason for transfer. A clinical record review revealed Resident 81 was admitted on [DATE]. The resident was transferred to a community hospital on July 22, 2025, and readmitted on [DATE]. A review of the facility-initiated transfer notification form dated July 22, 2025, revealed the specific reason for transfer was not documented in writing for the resident or representative. A clinical record review revealed Resident 117 was admitted on [DATE]. The resident was transferred to a community hospital on May 29, 2025, and readmitted on [DATE]. A review of the transfer notification form dated May 29, 2025, revealed the facility did not provide the specific reason for the transfer in writing. During an interview on August 7, 2025, at approximately 1:30 PM, the nursing home administrator was unable to provide documented evidence that residents 3, 5, 81, 99, and 117, or their representatives, had received written notification of the specific reason for their transfers on the aforementioned dates. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined that the facility failed to refer residents with newly evident or possible serious mental disorders, intellectual disabilities, or related conditions for a Preadmission Screening and Resident Review (PASRR) level II resident review for one out of 28 residents (Resident 99).Findings include: Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long-term care. The PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness before admission. This is called a PASRR Level I screen. Those individuals who test positive for PASRR Level I are then evaluated in-depth; this is called PASRR Level II. The results of this evaluation result in a determination of need, a determination of an appropriate setting, and a set of recommendations for services for the individual's plan of care. A review of the Pennsylvania Department of Human Services Office of Long-Term Living Bulletin titled Revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level 1 Identification Form (MA 376), effective July 1, 2024, revealed if the individual has a change in condition that affects program office criteria as found on the PASRR Level I form, a PASRR Level II evaluation form will need to be completed. Nursing facilities will communicate the need to have a PASRR Level II form done by notifying the department's Office of Long-Term Living, Division of Nursing Facility Field Operations Team. A clinical record review revealed Resident 99 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder (a mood disorder characterized by persistent feelings of sadness and loss of interest in activities that impact daily life). Further clinical record review revealed Resident 99 was transferred to a community emergency department after a suicide attempt on April 2, 2025. Resident 99 was subsequently involuntarily committed to a community psychiatric hospital for evaluation and stabilization. Resident 99 was readmitted to the facility on [DATE]. A clinical record review revealed no documented evidence that the facility referred Resident 99 for a pre-admission screening and Resident Review level II through the state mental health authority following the emergence of his newly evident and serious maladaptive behaviors and readmission to the facility on April 15, 2025. During an interview on August 8, 2025, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed the facility failed to refer Resident 99 for a PASRR level II resident review after his suicide attempt on April 2, 2025, psychiatric hospitalization, and subsequent readmission to the facility on April 15, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 fully develop, revise, and implement a person-centered comprehensive care plan to meet the individualized needs of two residents out of 28 sampled (Resident 81 and 73).Finding include: A review of Resident 81's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin which is a hormone that helps regulate blood sugar levels or when the body cannot effectively use the insulin it produces). A quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 81 dated July 31, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 02 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). Observation of Resident 81 on August 5, 2025, at 1:00 PM, revealed the resident was Spanish speaking. During an interview at 1:15 PM on the same day, Employee 8, Licensed Practical Nurse, stated that Resident 81 required Spanish-speaking staff, family, or an interpreter to translate the care being rendered, but understood some basic English words. A review of the resident's comprehensive plan of care, last revised on August 1, 2025, failed to include interventions required to effectively communicate with the resident. Further review of the clinical record revealed the resident was at high risk for falls and had sustained a fall on July 22, 2025; however, the August 1, 2025, plan of care did not reflect updated medical treatment goals or interventions for fall prevention. An elopement risk assessment dated [DATE], identified the resident as being at risk for wandering, yet the same plan of care failed to include updated treatment goals and interventions for elopement and wandering risk. During an interview on August 7, 2025, at approximately 10:00 AM, the Nursing Home Administrator confirmed the facility failed to ensure that the comprehensive care plan was fully developed for Resident 81. A clinical record review revealed that Resident 73 was admitted to the facility on [DATE], with diagnoses that included cerebral palsy (group of conditions affecting movement and posture caused by damage that occurs to the developing brain, usually before birth), quadriplegia (paralysis of both arms and legs), abnormalities of gait and mobility, and need for assistance with personal care. A falls risk assessment dated [DATE], identified the resident as moderate risk for falls. A review of the resident's comprehensive care plan, dated May 14, 2025, identified deficits in Activities of Daily Living (ADLs) related to musculoskeletal impairments. Interventions included: use of high back wheelchair with pressure relieving cushion and bilateral leg rests, dependent with bathing/showering with assistance of one staff member, dependent with dressing and eating, assistance of 2 staff members for repositioning and turning in bed, and use of a mechanical lift for transfers. During an interview with the Nursing Home Administrator (NHA) on August 7, 2025, at 1:30 PM, the NHA stated that nurse aides utilize the Kardex system (a nursing information system used to obtain up-to-date specific care information for each resident) to be informed of resident care directives and level of assistance required to perform tasks. A review of the resident's Kardex, dated June 29, 2025, did not reflect the resident's bed mobility status or indicate that two staff members were required to safely reposition the resident in bed, as outlined in the care plan. In a follow-up interview on August 8, 2025, at approximately 9:30 AM, the NHA was unable to provide documented evidence that the bed mobility interventions developed in the resident's care plan had been incorporated into the Kardex or otherwise communicated to direct care staff. Specifically, there was no documentation to support that staff were informed that two caregivers were required for safe repositioning and turning the resident in bed for personal care and hygiene. Refer F689 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1) 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 clinical record review, select facility policy, and staff interviews, it was determined that the facility failed to provide person-centered care for diabetes management and professional standards of practice for one resident out of 28 sampled (Resident 81). Findings include:A review of Resident 81's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin (a hormone that helps regulate blood sugar levels) or when the body cannot effectively use the insulin it produces). A quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 81 dated July 31, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 02 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). A review of facility policy entitled Care of the Diabetic Resident, last reviewed on June 19, 2025, revealed that if an Accu-Chek (a brand of blood glucose monitoring device used to measure the amount of glucose in the blood, reported in milligrams per deciliter [mg/dL]) reveals a blood glucose level below 70 mg/dL, or a level identified per individual physician's orders, then hypoglycemia should be suspected, and the resident's individual hypoglycemic protocol should be followed if ordered by a physician, and if no individual protocol is ordered, then the physician should be updated based on clinical assessment and current blood sugar. Further review indicated that hypoglycemia should be treated promptly with 15 to 20 grams of fast-acting carbohydrates if blood glucose levels are less than 70 mg/dL. A clinical record review for Resident 81 revealed physician orders, dated January 28, 2025, for insulin aspart (fast acting) with sliding scale parameters for subcutaneous (injection under the skin) injection dependent on the resident's blood glucose levels, to be administered four times daily with meals and at bedtime. Orders specified:70-149 mg/dL: 0 units of insulin< (less than)70 mg/dL: Call physician and notify the RN supervisor150-199 mg/dL: 2 units200-249 mg/dL: 4 units250-299 mg/dL: 6 units300-349 mg/dL: 8 units350-400 mg/dL: 10 units400 mg/dL: Contact the physician A clinical record review for Resident 81 revealed physician orders, dated May 22, 2025, for Novolog Insulin mix 70/30 subcutaneously for 10 units in the afternoon and to hold if blood glucose is less than 90 mg/dL. A review of a nursing note dated July 22, 2025, at 4:05 PM, revealed that Resident 81's Humalog 70/30 10 units was held due to a blood glucose level of 54 mg/dL (normal 70mg/dL to 110 mg/dL). A nursing progress note dated July 22, 2025, at 4:43 PM, revealed the resident had a fall out of their wheelchair, was lethargic but responsive, and that vital signs (blood pressure and heart rate) were normal, but the blood glucose was 57 mg/dL. Further review of the nurse's note revealed they were given orange juice per the hypoglycemic protocol. However, there was no documented evidence that Resident 81 received orange juice or any other carbohydrate in a timely manner after the initial hypoglycemic reading of 54 mg/dL at 4:05 PM. There was also no documented evidence that the RN supervisor was notified immediately of the low blood glucose level as required by physician orders; the RN supervisor was only notified after the fall occurred. Likewise, there was no documented evidence that the physician was notified of the hypoglycemia before being informed of the fall. During an interview with the Nursing Home Administrator on August 8, 2025, at approximately 1:00 PM, it was confirmed there was no documented evidence that Resident 81 received carbohydrates per hypoglycemic protocol in a timely manner during a hypoglycemic event and that no documented evidence that the physician and RN supervisor were notified of a low blood glucose until after a fall for Resident 81. 28 Pa Code 211.12 (c)(d)(1)(3)(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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, facility investigative documentation, and staff interviews, it was determined the facility failed to implement necessary safety interventions to prevent a fall and maintain the physical health of one resident (Resident 73) out of 28 residents reviewed.Findings include: A review of the facility policy titled Fall Reduction Policy last reviewed by the facility on June 19, 2025, revealed it is the facility's policy to provide an environment that remains free of accident hazards as possible, to identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries, and to promote a systemic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk. A clinical record review revealed that Resident 73 was admitted to the facility on [DATE], with diagnoses that included cerebral palsy (group of conditions affecting movement and posture caused by damage that occurs to the developing brain, usually before birth), quadriplegia (paralysis of both arms and legs), abnormalities of gait and mobility, and need for assistance with personal care. A falls risk assessment dated [DATE], identified the resident as moderate risk for falls. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 6, 2025, revealed that Resident 73 was moderately cognitively impaired with a BIMS score of 10 (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 8-12 indicates moderate cognitive impairment), had an impairment on both sides of his upper extremity (arm) and lower extremity (leg), required total assistance to roll left and right in bed. A review of the resident's care plan dated May 14, 2025, identified deficits in Activities of Daily Living (ADLs) related to musculoskeletal impairments. Interventions included: use of high back wheelchair with pressure relieving cushion and bilateral leg rests, dependent assistance for bathing/showering with one staff member, dependent assistance for dressing and eating, assistance of two staff members for repositioning and turning in bed, and the use of a mechanical lift for transfers. The Registered Nurse (RN) Supervisor assessed the resident. Vital signs were stable (blood pressure 140/88 mmHg, pulse 74 beats per minute, temperature 97.1 F, respirations 18 per minute, oxygen saturation 98% on room air). The resident denied hitting his head or experiencing pain, and a staff member confirmed no head impact occurred. The resident stated, I rolled out of bed. The resident was returned to bed using a Hoyer lift (a mechanical lift used to transfer residents who cannot bear weight), and safety measures were put in place. The physician and responsible party were notified. Review of nursing documentation dated July 1, 2025, at 10:56 AM indicated the resident was complaining of pain in his left shoulder, left elbow, left ribs, and left hip. Tylenol was administered. The physician was made aware and ordered and x-ray of the left upper extremity (arm), rib and hip. Review of the x-ray report dated July 1, 2025, revealed no acute (new) fractures or dislocations. Soft tissue swelling of the left forearm was noted. A review of a facility provided documentation dated July 2, 2025, at 3:15 PM revealed that Employee 4, nurse aide, failed to follow the resident's plan of care, requiring assistance of two staff members for bed mobility/rolling left or right. In a written witness statement dated June 30, 2025, at 9:30 PM, Employee 4 described the incident: while providing care, Employee 4 rolled the resident away from her, briefly removing a hand to reach for a brief on the bedside table. During this moment, the resident rolled off the bed despite Employee 4's attempt to prevent the fall and protect the resident's head. Continued review of the witness statement revealed Employee 4 was asked three follow-up questions: 1. How many staff should be with the resident with transfers? Employee 4 answered Two. 2. How many staff should be with the resident with bed mobility? Employee 4 answered One.3. Which way was the resident rolled in bed? Employee 4 answered rolled him (the resident) away from me. He has two spots between his butt and thigh that needs skin protectant cream applied. If I would have had that second person, it would've been easier to apply the cream. Employee 4 continued to add I was doing what I was told when I was on 1st floor hired two years ago. I would do his bed cares with one person; I would also have a second person there for all transfers. During an interview with the Nursing Home Administrator (NHA) on August 7, 2025, at 1:30 PM, the NHA stated that nurse aides use the Kardex (a nursing information system used to obtain up-to-date specific care information for each resident) to determine the level of assistance required for resident care tasks. During an interview with Employee 4 on August 7, 2025, at 11:40 AM, she confirmed that staff rely on the Kardex for this information but that

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, a review of select facility policy and staff interview, it was determined the facility failed to implement procedures to ensure acceptable storage and use by dates for multi-dose medications in two of three medication storage rooms (second and third floor medication rooms). Findings include: A review of the facility policy titled Medication Storage, last reviewed by the facility June 19, 2025, indicated the purpose is to ensure medications and biologicals are stored in a safe, secure storage area and ensure safe handling. Multi-use vials must be dated upon opening and discarded within 30 days unless otherwise specified by manufacturer. An observation of the medication room on the second floor on August 7, 2025, at 8:30 AM of medications stored in the medication refrigerator revealed a multi-dose bottle of Tuberculin (solution used for screening for tuberculosis) that had been opened, available for use, and dated July 2, 2025. Review of the manufacturer dosage and administration for Tuberculin revealed that vials in use for more than 30 days should be discarded. The current vial was 36 days beyond the manufacturer's recommended discard date. Interview with Employee 2 (Registered Nurse, Unit Manager) at the time of the observation on August 7, 2025, at 8:30 AM confirmed the Tuberculin vial was dated when opened on July 2, 2025, and was beyond the manufacturer recommended use by date (30 days) and had not been discarded within 30 days of opening. An observation of the medication room on the third floor on August 7, 2025, at 8:45 AM of medications stored in the medication refrigerator revealed a multi-dose bottle of Tuberculin that had been opened, available for use, and not dated when opened. Interview with Employee 1(licensed practical nurse) at the time of the observation on August 7, 2025, at 8:45 AM confirmed the Tuberculin vial was opened and not dated. Interview with the Nursing Home Administrator and Director of Nursing on August 7, 2025, at approximately 1:00 PM confirmed that medications are to be dated upon opening and expiration/use by dates were to be checked prior to administration and removed from the medication refrigerator upon expiration. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services. 28 Pa. Code 211.10 (d) Nursing care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.