STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395345	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Rehabilitation & Healthcare Center	615 Wyoming Avenue Kingston, PA 18704

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the Resident Assessment Instrument (RAI) User's Manual and staff interviews, it was determined the facility failed to ensure the Minimum Data Set assessments (MDS) accurately reflected the clinical status of 3 of twenty residents reviewed (Residents 59, 45, and 66).Findings include: A clinical record review revealed Resident 59 was admitted on [DATE], with diagnoses including traumatic brain injury (an injury to the brain caused by an external force that can affect thinking, movement, and behavior), bipolar disorder (a mental health condition characterized by periods of elevated and depressed mood), and intellectual disability (limitations in mental functioning affecting learning and daily living skills). A review of the Medication Administration Record (MAR, a legal document that records medications and treatments administered to a resident) dated October 2025 revealed the resident received a one-time intravenous hydration infusion (IV, fluids delivered directly into a vein) of normal saline solution (a sterile saltwater solution used to replace fluids and electrolytes) totaling 1000 milliliters at a rate of 500 milliliters per hour on October 22, 2025. The infusion included micronutrients such as B-complex vitamins B1 200mg, B2 4 mg, B5 4 mg, B6 4 mg, B3 200 mg (a group of vitamins that support metabolism but do not provide calories), vitamin B12, zinc, magnesium, and calcium for hydration and wellness purposes. Resident 59's quarterly MDS dated [DATE], revealed Section K0520 (Nutritional Approaches) was coded yes for parenteral or IV feeding (nutrition delivered directly into the bloodstream), and Section K0710 (intake by artificial route) was coded to reflect intake by IV. The Resident Assessment Instrument (RAI) User's Manual, a reference guide used to properly code the MDS) Minimum Data Set Assessment (MDS a federally required standardized assessment used to evaluate a resident's condition and guide care planning) specifies that IV fluids administered for hydration or as a vehicle for medications are not to be coded as parenteral feeding. The infusion consisted of fluids and micronutrients only and did not include nutrients such as calories, protein, fat, or carbohydrates required to meet nutritional needs. The clinical record did not contain documentation to support that the IV therapy met criteria for nutritional support. Therefore, Sections K0520 and K0710 were coded inaccurately. Review of Resident 59's November 2025 MAR revealed a similar one-time IV hydration infusion administered on November 19, 2025, at 12:35 PM consisting of fluids and micronutrients, B complex vitamins, vitamin B12, zinc, magnesium, and calcium for hydration and wellness purposes The quarterly MDS for Resident 59 dated November 21, 2025, again coded Section K0520 and K0710 to reflect IV feeding. The clinical record did not support that the infusion qualified as nutritional support per the RAI criteria. These sections were coded inaccurately. A clinical record review revealed Resident 45 was admitted on [DATE], with diagnoses including type two diabetes (a condition in which blood sugar levels are elevated due to problems with insulin), muscle atrophy (loss of muscle mass), and vascular dementia (cognitive decline caused by reduced blood flow to the brain). A review of Resident 45's Medication Administration Record MAR, dated January 2026 revealed the resident received a physician-ordered, one-time intravenous hydration infusion on January 14, 2026, at 12:30 PM through an outside contracted infusion service. The infusion consisted of 0.9 percent normal saline solution (a sterile saltwater solution used to replace fluids and electrolytes) totaling 1000 milliliters, administered at a (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rate of 250 milliliters per hour via a peripheral IV (a small flexible tube inserted into a vein for short-term fluid or medication administration).The infusion also contained added micronutrients and supplements, including vitamin C, B-complex vitamins vitamin B12, zinc, magnesium, calcium, and amino acids (building blocks of protein used by the body for tissue repair), which were provided for hydration and general wellness purposes.A review of Resident 45's quarterly MDS dated [DATE], revealed Section K0520 (Nutritional Approaches) was coded yes to indicate the resident received parenteral or IV feeding during the seven-day look-back period.Additionally, Section K0710 (Intake by Artificial Route) was coded to indicate the resident received a portion of calories and fluids through an artificial route during the assessment period.The Resident Assessment Instrument (RAI) User's Manual specifies that IV fluids administered for hydration or as a vehicle for medications are not to be coded as parenteral feeding under Section K0520.The clinical record did not contain documentation to support that the IV infusion was used to provide nutrition, such as calories, protein, fat, or carbohydrates required to meet nutritional needs. Therefore, the coding of Sections K0520 and K0710 on the January 14, 2026, MDS was inaccurate. A clinical record review revealed Resident 66 was admitted on [DATE], with diagnoses including cerebral infarction (brain damage caused by loss of blood flow), protein calorie malnutrition (a condition in which the body does not receive enough calories and protein), and cognitive communication deficits (difficulty communicating due to impaired thinking processes). A review of the November 2025 MAR revealed the resident received a one-time intravenous hydration infusion on November 19, 2025, consisting of normal saline with added micronutrients including B-complex vitamins, vitamin B12, zinc, magnesium, and calcium. The quarterly MDS dated [DATE], coded Section K0520 as yes for parenteral or IV feeding and Section K0710 to reflect intake by artificial route. The infusion consisted of fluids and micronutrients only and did not include nutrients such as calories, protein, fat, or carbohydrates required to meet nutritional needs. The clinical record did not support that the IV infusion was used for nutritional feeding. Per the RAI User's Manual, this type of IV therapy does not meet criteria for coding under Section K. The MDS was coded inaccurately. Further review of the December 2025 MAR revealed an additional one-time intravenous hydration infusion administered on December 17, 2025, consisting of fluids and micronutrients. The quarterly MDS dated [DATE], again coded Section K0520 and K0710 to reflect IV feeding. The clinical record did not contain documentation supporting that the infusion met criteria for parenteral nutrition. These sections were coded inaccurately. During an interview with the facility's Nursing Home Administrator (NHA) on April 24, 2026, at 11:30 AM, the above findings were reviewed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, and staff interviews, it was determined the facility failed to consistently monitor residents' nutritional and hydration status to timely identify declines, implement individualized and less invasive interventions, and ensure clinical justification prior to initiating invasive interventions for three of twenty residents reviewed (Residents 59, 45, and 66). This deficiency is cited as past noncompliance.Findings include: A review of a facility policy entitled Weight Assessment and Interventions last reviewed by the facility on May 20, 2025, indicated each resident's weight will be monitored by the interdisciplinary team and intervene for undesirable weight loss. Any weight change of percent or more since the last weight assessment will be retaken for confirmation and if the weight is verified, nursing will immediately notify the Registered Dietitian. The threshold for significant unplanned and undesired weight loss will be based on 5 percent weight loss is significant and any change greater than in one month is severe, 7.5 percent weight loss is significant and any change greater than in three months is severe, and 10 percent weight loss is significant and any change greater than in six months is severe. A review of a policy entitled Early Interventions for Weight Loss Guidelines last reviewed by the facility on May 20, 2025, indicated that identification of unplanned, significant weight loss, especially in the case of greater than 5 percent in a thirty-day period, should lead to the implementation of appropriate nutrition interventions. Interventions should be discussed with the interdisciplinary team at the morning clinical meeting. A food first approach should be utilized when selecting an early intervention for unplanned weight loss. Early intervention include, but not limited to: focus on food preferences, appropriate food consistency snacks, fortified foods (foods enhanced to increase calories and protein), and meal tray extras, assistance with eating or assistive devices to increase independence, more liberalized diet to increase food and fluid variety, changing meal environment to remove distractions or barriers to intake, family involvement with visits or assistance at mealtimes, and assessment for depression and dementia. A clinical record review revealed Resident 59 was admitted to the facility on [DATE], with diagnoses that included traumatic brain injury (TBI, injury (a brain injury caused by an external force affecting thinking, movement, or behavior), bipolar disorder (a mental health condition with mood swings), and unspecified intellectual disabilities (limitations in intellectual functioning and daily living skills). A review of Resident 59's quarterly Minimum Data Set (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], revealed the residents Brief Interview for Mental Status (BIMS, 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 0-7 indicates severe cognitive impairment) score was 4, severe cognitive impairment. The resident required supervision and assistance with eating. A clinical record review revealed the registered dietitian completed a nutrition progress note on September 25, 2025, at 8:07 PM, which identified significant weight loss for Resident 59 exceeding five percent in one month and ten percent in six months. The note documented the following weights: September 24, 2025: 184.6 poundsAugust 25, 2025: 195.2 pounds, reflecting a 5.4 percent loss in one monthJune 3, 2025: 202.4 pounds, reflecting an 8.8 percent loss in three monthsMarch 3, 2025: 203.4 pounds, reflecting a 9.2 percent loss in six months The dietitian documented significant weight loss over thirty days and ninety days. At that time, Resident 59 received a regular diet with pureed textures, thin liquids, fortified foods with meals, Health Shakes, and ice cream with lunch and dinner. Fortified foods are foods enhanced to increase calories and protein, such as mashed potatoes, pudding, and hot cereal. Food intake averaged 26 to 100 percent at meals with Health Shakes (oral nutritional supplements used to provide additional calories and protein) and ice cream (initiated October 8, 2024) provided with lunch and dinner meals for nutrition support. The dietitian recommended increasing Health Shakes to all meals and obtaining weekly weights for four weeks to closely monitor the resident's weight trend (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and allow timely intervention. However, the clinical record failed to show that Health Shakes were ordered three times per day with meals until September 26, 2025, at 8:00 AM. Weekly weights after the dietitian's recommendation were recorded as follows: September 29, 2025: 184 poundsOctober 2, 2025: 186.2 poundsOctober 6, 2025: 183.3 poundsOctober 13, 2025: 194.6 poundsOctober 17, 2025: 183.4 pounds These weights continued to show fluctuation and did not demonstrate consistent stabilization after the significant weight loss was identified. A review of a Physician/Certified Registered Nurse Practitioner (CRNP) progress note dated October 16, 2025, at 11:53 AM, revealed Resident 59 had ongoing low fluid intake despite reported interventions. The CRNP documented the resident had recent weight loss, decreased appetite, recent falls, and a decreased sense of thirst. Interventions included encouraging fluids during meals, offering preferred beverages, and an order to increase oral (by mouth) fluid intake. However, the clinical record failed to contain consistent documentation that these oral hydration interventions were implemented or effective. The CRNP determined that intravenous (IV) hydration (fluid administered directly into a vein to treat or prevent dehydration) was appropriate to prevent further decline. The physical assessment noted continued weight loss, no swelling (edema), and no signs of fluid overload (excess fluid in the body). Staff reported no difficulty swallowing, nausea, or vomiting. A review of Resident 59's Medication Administration Record (MAR), (legal record of medications and treatments administered), revealed that on October 22, 2025, at 8:03 AM, six days after the CRNP identified the need, the resident received a one-time IV infusion. The infusion consisted of one thousand milliliters of normal saline (a sterile saltwater solution used to replace fluids) administered at a rate of five hundred milliliters per hour through a peripheral IV (a small tube inserted into a vein for short-term fluid administration). The infusion also included vitamins and minerals (micronutrients), including B-complex vitamins, vitamin B12, zinc, magnesium, and calcium. A subsequent dietitian assessment dated [DATE], noted continued significant weight loss, including a 5.2 percent loss over one month and an 8.8 percent loss over six months. The resident received a regular diet with pureed texture, fortified foods (foods enhanced to increase calories and protein), Health Shakes (oral nutritional supplements), and ice cream for additional caloric intake. Meal intake ranged from 51 to 100 percent, and the resident required staff assistance for eating. The dietitian documented a slight weight gain trend following increased oral supplementation and planned continued monitoring for weight stabilization.The clinical record failed to demonstrate that oral hydration and nutrition interventions were fully implemented, monitored for effectiveness, and exhausted prior to initiating IV hydration. In addition, the record failed to include laboratory data (blood tests used to assess hydration and electrolyte balance) to clinically support the need for IV hydration administered on October 22, 2025.Further review of CRNP progress notes dated November 13, 2025, December 11, 2025, and January 8, 2026, continued to document low fluid intake with similar findings and recommendations for IV hydration, despite limited documented evidence that oral hydration strategies were consistently implemented or evaluated for effectiveness.A review of subsequent MARs revealed the resident received additional one-time IV micronutrient infusions on November 19, 2025, December 17, 2025, and January 14, 2026, using the same solution and administration method.However, the clinical record failed to demonstrate that laboratory testing was obtained prior to these treatments to support a clinical need for IV hydration. Additionally, the record failed to show that individualized, less invasive nutritional and hydration interventions were attempted, evaluated, and found ineffective prior to repeated use of IV therapy. A review of Resident 45's clinical record revealed admission to the facility on June 22, 2022, with a diagnosis including type two diabetes (a condition causing high blood sugar), muscle wasting (loss of muscle mass), and vascular dementia (decline in thinking due to reduced blood flow to the brain). A review of Resident 45's quarterly assessment dated [DATE], revealed the residents Brief Interview for Mental Status (BIMS) score was 3, a score of 0-7 indicates severe cognitive impairment. The resident required set up or clean-up assistance with meals. A clinical record review revealed physician orders for a controlled carbohydrate diet with regular texture and thin liquids, Health Shake (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once daily with dinner, and a liquid protein supplement 30 milliliters daily for skin integrity.A review of the resident's weight record revealed the following:December 1, 2025: 135.6 poundsJanuary 1, 2026: 122.8 poundsJanuary 2, 2026 (reweigh): 124.2 poundsThese weights reflect a loss of 11.4 pounds, or 8.4 percent, in one month, which is considered significant. A dietitian progress note dated January 6, 2026, at 7:02 AM, confirmed the significant weight loss of 8.4 percent in one month. Meal intake ranged from 51 to 100 percent. The resident accepted the Health Shake but refused the liquid protein supplement, with zero percent intake documented. The dietitian recommended discontinuing the liquid protein supplement due to poor acceptance and initiating weekly weights for four weeks to closely monitor weight trends. The note also referenced thyroid testing, including TSH (thyroid stimulating hormone, a blood test used to evaluate thyroid function), with follow-up scheduled and recent adjustment to Levothyroxine (a medication used to treat thyroid conditions).A review of a Physician/Certified Registered Nurse Practitioner (CRNP) progress note dated January 8, 2026, at 9:49 AM, revealed the resident had persistent low fluid intake despite reported interventions, including encouragement of fluids during meals and offering preferred beverages. The record failed to contain consistent documentation supporting that increased oral fluid intake was implemented or effective. The CRNP noted the resident had recent weight loss, decreased appetite, recent falls, and decreased perception of thirst, and determined intravenous (IV) hydration (fluid administered directly into a vein to treat or prevent dehydration) was appropriate. The physical assessment noted continued weight loss with no signs of edema (swelling) or fluid overload. Staff reported no difficulty swallowing, nausea, or vomiting. A review of the Medication Administration Record revealed the resident received a one-time IV micronutrient infusion on January 14, 2026, at 12:30 PM. The infusion consisted of one thousand milliliters of normal saline (a sterile saltwater solution used to replace fluids) administered at a rate of 250 milliliters per hour through a peripheral IV (a small tube inserted into a vein for short-term treatment). The infusion included vitamins and minerals such as vitamin C, B-complex vitamins, vitamin B12, zinc, magnesium, calcium, taurine, glycine, folic acid, and glutamine. A review of a basic metabolic panel (a group of blood tests used to evaluate hydration status, kidney function, and overall health) collected on January 14, 2026, at 8:08 AM, and reported the same day at 5:14 PM, revealed the following results for Resident 45:Blood Urea Nitrogen (BUN), a test used to assess kidney function and hydration status, was 13 milligrams per deciliter, which is within the normal range of 6 to 20.Creatinine, a blood test used to evaluate kidney function, was 0.6 milligrams per deciliter, which is within the normal range of 0.5 to 1.0.Estimated Glomerular Filtration Rate (eGFR), a calculation used to determine how well the kidneys filter waste, was 89 milliliters per minute, which is within normal limits.Sodium, an electrolyte that helps regulate fluid balance, was 142 millimoles per liter, which is within the normal range of 135 to 146.Potassium, an electrolyte important for heart and muscle function, was 4.7 millimoles per liter, which is within the normal range of 3.5 to 5.1.Chloride, an electrolyte that helps maintain fluid and acid balance, was 104 millimoles per liter, which is within the normal range of 98 to 107.Glucose, a measure of blood sugar, was 145 milligrams per deciliter, which is above the normal range of 70 to 120.Albumin, a protein used as an indicator of nutritional status, was 4.1 grams per deciliter, which is within the normal range of 3.8 to 5.0.Total protein, a measure of overall protein levels in the blood, was 7.3 grams per deciliter, which is within the normal range of 6.0 to 8.3.Prealbumin, a test used to assess short-term nutritional status, was 22 milligrams per deciliter, which is within the normal range of 18 to 45.All laboratory values were within normal limits, except for an elevated glucose level.The MAR review revealed the micronutrient infusion was administered on January 14, 2026, at 12:30 PM. The facility could not provide documented evidence of weekly weights being completed on January 9, 2026, January 16, 2026, January 23, or January 30, 2026, as recommended by the RD to monitor weight after a significant weigh loss from December 1, 2025, to January 2, 2026.The record failed to demonstrate that less invasive nutritional and hydration interventions were attempted and evaluated prior to initiating IV therapy. A clinical record review revealed Resident 66 was admitted to the facility on [DATE], with diagnoses that included cerebral (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients), protein calorie malnutrition (lack of adequate protein and calories), and cognitive communication deficits (occurs when a person's ability to communicate effectively is compromised due to impairments in cognitive processes such as attention, memory, and executive functions, rather than a direct problem with language or speech). A review of Resident 66's annual MDS assessment dated [DATE], revealed that the residents Brief Interview for Mental Status score was 15, indicating intact cognition. The resident was not receiving a mechanically altered diet, but received a therapeutic diet, and required setup or clean-up assistance with meals. A review of Resident 66's weight record revealed the following:October 1, 2025: 134.8 poundsOctober 7, 2025: 128.8 poundsThis reflects a loss of 6 pounds within one week, which is a significant and rapid weight decline.A dietitian progress note dated November 6, 2025, at 8:02 PM, completed thirty-one days after the initial weight loss, documented continued concern. The note referenced a weight of 127.7 pounds obtained on November 1, 2025, which was later crossed out by nursing staff on November 12, 2025. Based on the available data, the dietitian identified a weight loss of 7.1 pounds, or 5.3 percent, over one month.Additional weight comparisons included:October 1, 2025: 134.8 pounds, reflecting a 5.3 percent loss over one monthAugust 5, 2025: 133.4 pounds, reflecting a 4.3 percent loss over three monthsMay 1, 2025: 133.4 pounds, reflecting a 4.3 percent loss over six monthsThe dietitian noted the resident's weight was considered underweight for advanced age and identified significant weight loss over thirty days. At that time, the resident was receiving a regular diet with regular texture and thin liquids, with meal intake ranging from fifty-one to one hundred percent. Recommendations include providing fortified foods (food enhanced to increase calories and protein) with all meals and obtaining weekly weights for four weeks to monitor for stabilization or gain.The clinical record failed to demonstrate that these interventions were implemented timely following the initial significant weight loss identified in early October 2025. A review of a Certified Registered Nurse Practitioner (CRNP) progress note dated November 13, 2025, at 11:28 AM, documented increased cognitive decline and continued low fluid intake. Interventions included offering fluids, encouraging intake, and providing preferred beverages. Despite these efforts, the resident's intake remained inadequate, and intravenous (IV) hydration (fluid administered directly into a vein to treat or prevent dehydration) was determined to be appropriate. The physical assessment noted no swelling (edema) and no signs of fluid overload. Staff reported no difficulty swallowing, nausea, or vomiting.A review of the Medication Administration Record (MAR), the legal record of treatments administered, revealed the resident received a one-time IV micronutrient infusion on November 19, 2025, at 12:30 PM, six days after the CRNP identified the need. The infusion consisted of one thousand milliliters of fluid administered at a rate of one thousand milliliters per hour through a peripheral IV (a small tube inserted into a vein for short-term treatment) and included vitamins and minerals such as B-complex vitamins, vitamin B12, zinc, magnesium, and calcium. Resident 66's clinical record failed to demonstrate that less invasive nutritional and hydration interventions were implemented, monitored, and determined to be ineffective prior to initiating IV therapy.During an interview on April 23, 2026, at 12:45 PM, the Director of Nursing stated that residents with decreased intake were referred to the CRNP to determine if IV micronutrient therapy was appropriate. During an interview on April 24, 2026, at 11:00 AM, the Nursing Home Administrator confirmed that weight monitoring was not completed timely, and that less invasive nutritional and hydration interventions should have been attempted prior to implementing IV therapy. This deficiency was cited as past non-compliance. The facility's corrective action plan included the following: Residents that were receiving IV hydration were reviewed and the physician/NP (nurse practitioner) clarified orders to ensure clinical indication, evidence of less invasive measures attempted, and duration and monitoring parameters. Residents were assessed for oral intake capacity, swallow status, cognitive ability to participate, and reversible causes (i.e. urinary tract infection, medications, constipation). Residents who received IV therapy in the last three months were reviewed to ensure decline in nutrition/hydration status was documented and (continued on next page)

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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 on observations, resident and staff interviews, clinical record review, and review of facility policy, it was determined the facility failed to provide a comfortable and homelike environment by failing to maintain acceptable sound levels from the resident call bell system on one of three floors observed (Fourth Floor), which resulted in ongoing excessive noise that disrupted rest and comfort for three residents (Residents 6, 61, and 73).Findings include: A review of the policy titled Call System, Resident last review May 20, 2025, revealed residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. An interview with Employee 1 Nurse Aide, on April 21, 2026, revealed the call bell system malfunctioned on April 20, 2026, and, although repaired, remained set only at the loudest volume. Employee 1 stated staff notified maintenance of the excessive loudness. A review of the clinical record revealed Resident 6 on October 9, 2023, with a diagnosis to include Rheumatoid arthritis (an autoimmune disease that primarily affects the joints causing pain and swelling and stiffness) and Diabetes Mellitus (a metabolic disorder in which the body has high sugar levels for a prolonged period). A review of the quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 2, 2026 revealed that Resident 6 was cognitively intact with a BIMS score of 14 (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 13-15 indicates cognition is intact). During an interview on April 21, 2026, at 11:30 AM, Resident 6 reported the call bell noise during the night was extremely loud and disruptive to sleep, stating, I got no sleep, that thing is so loud. A clinical record review revealed Resident 61 was admitted on [DATE], with diagnoses including orthopedic aftercare following surgical amputation (post-surgical recovery focused on healing and preventing complications after removal of a body part) and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for a prolonged period). A review of the quarterly MDS dated [DATE], revealed that Resident 6 was cognitively intact with a BIMS score of 13. During an interview on April 21, 2026, at 11:45 AM, Resident 61, whose room was located directly across from the nurse's station, reported repeated sleep disruption due to the call bell speaker outside the room, stating, I didn't sleep. Every time the bell went off, it woke me up. The speaker is right outside my door. That bell rang all night. An observation on April 22, 2026, at 9:00 AM revealed the call bell system on the Fourth Floor continued to operate at the loudest setting, indicating the condition remained uncorrected. A clinical record review revealed Resident 73 was admitted on [DATE], with diagnoses including poly-osteoarthritis (degenerative joint disease causing pain and stiffness in multiple joints) and lack of coordination (impaired ability to perform smooth, controlled movements). A review of the MDS dated [DATE], indicated Resident 73 was cognitively intact with a BIMS score of 14. During an interview on April 22, 2026, at 10:39 AM, Resident 73 reported the call bell noise was amplified (increased in volume) when wearing hearing aids, resulting in discomfort. The resident stated I take the hearing aids out at night, so it wasn't awful, but during the day it is terribly loud, I don't want to take them out. I won't be able to hear anything else. An interview with the Nursing Home Administrator on April 22, 2026, at 12:00 PM was conducted to review the above findings related to the facilities failure to provide a homelike environment for residents including maintaining sound levels that do not interfere with residents' comfort, rest, or ability to sleep. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility for one resident out of 20 residents reviewed (Resident 79).Findings include: Review of the facility Restorative Nursing Services Policy, last reviewed May 20, 2025, revealed that residents will receive restorative nursing care (RNP) as needed to help promote optimal safety and independence. Review of the policy revealed that the resident's restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a chronic joint condition in which the protective cartilage breaks down, resulting in pain, stiffness, and decreased movement) and abnormal posture. A review of Resident 79's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 9, 2026, revealed that Resident 79 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates moderate cognitive impairment). A review of the clinical record indicated physical therapy services were provided from March 12, 2026, through April 7, 2026. A review of the physical therapy Discharge summary dated [DATE], indicated the resident was able to ambulate 10 to 25 feet with the assistance of one staff person using a front-wheeled walker (a mobility device with wheels that assists with balance and walking). Discharge recommendations included continued use of an assistive device, assistance with activities of daily living (routine self-care tasks such as bathing, dressing, and toileting), and implementation of a restorative nursing program. The discharge summary indicated restorative nursing program interventions were developed and communicated to the Interdisciplinary Team (IDT, a group of healthcare professionals responsible for coordinating resident care), including ambulation of approximately 15 feet with a front-wheeled walker with assistance of one staff person to maintain functional mobility and prevent decline. A review of the Resident 79's care plan, in effect through the survey end date of April 24, 2026, identified a focus area for impaired range of motion with an intervention for active range of motion exercises (movements performed by the resident using their own muscle strength to maintain joint flexibility) to the right upper extremity for at least 15 minutes. A review of Resident 79's electronic task report (a system-generated record that tracks scheduled and completed care tasks) and the Documentation Survey Report for April 2026 revealed multiple shifts in which restorative nursing interventions were not documented as completed. Review of the clinical record revealed no consistent documentation to support that restorative nursing services, including ambulation and range of motion exercises, were provided as planned. An interview with Resident 79 on April 22, 2026, at 10:00 AM indicated the resident was upset due to the lack of consistent restorative nursing services. The resident reported a desire to participate in therapy and restorative nursing to improve mobility and return home. The resident stated that certain staff members assist with the task but often staff are busy and do not help her. During an interview on April 23, 2026, at 11:30 AM, the Director of Nursing reviewed the above findings and was unable to provide documented evidence that the facility consistently implemented the restorative nursing program for Resident 79 as planned. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa Code 211.12(c)(d)(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 observations, a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to ensure the environment remained free from potential accident hazards related to the unsafe storage and access of medications for one of three nursing units reviewed (Unit 4) and for one of 20 residents sampled (Resident 58).Findings included: A review of the facility policy titled Administering Medications, last reviewed May 20, 2025, revealed it is the facility policy that medications are administered in a safe and timely manner and as prescribed. A review of the facility policy titled Self-Administration of Medications, last reviewed May 20, 2025, revealed it is the facility policy that self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in a resident's room, the medication of residents permitted to self-administer is stored on a central medication cart or in the medication room. A clinical record review revealed Resident 58 was admitted to the facility on [DATE], with diagnoses that included peripheral vascular disease (a slow, progressive circulation disorder involving narrowing, blockage, or spasms in blood vessels) and muscle weakness. The clinical record revealed no documented assessment indicating Resident 58 was evaluated and approved to self-administer medications. Review of physician orders revealed an order dated November 5, 2025, for Ipratropium Bromide 0.03% nasal solution (a prescription medication used to relieve nasal symptoms such as runny nose), to be administered once daily in each nostril. Observation conducted on April 22, 2026, at 09:30 AM revealed a bottle of Ipratropium Bromide nasal spray and an opened bottle of Tums (an over-the-counter medication containing calcium carbonate used to relieve heartburn) located on the resident's bedside table and accessible to the resident. Interview with Resident 58 at the time of the observation revealed the resident used the medications as needed and confirmed staff left the medications at the bedside for his use. Review of the clinical record revealed no physician order for the over-the-counter Tums observed at the bedside. During an interview on April 22, 2026, at 11:00 AM, the Nursing Home Administrator reviewed the above findings, including that nursing staff left medications accessible at the bedside without evidence the resident had been assessed or approved to self-administer. The facility failed to assess the resident's ability to safely self-administer medications and to ensure medications were securely stored to prevent the potential for improper use, incorrect dosing, or access by other residents. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of controlled drug shift count records, facility policy, and staff interviews, it was determined the facility failed to implement procedures to promote accurate controlled medication records for one of two medication carts observed.Findings include: A review of the facility policy titled Controlled Substances, medications regulated by federal and state law due to their potential for misuse, dependency, or diversion. Accurate counting and documentation are required to ensure accountability and to prevent loss or misuse) last reviewed May 21, 2025, revealed controlled medications are counted at the end of each shift. The oncoming licensed nurse and the off-going licensed nurse are required to complete the count together. The oncoming licensed nurse signs the controlled substance record to acknowledge receipt, and the off-going licensed nurse signs to verify the count was completed and correct. A review of the facility Controlled Drug Key Exchange Audit for the fourth floor back hall nursing unit (Rooms 408 to 416) medication cart revealed that on April 20, 2026, the evening shift off-going nurse failed to sign the controlled substance record to verify the narcotic count was completed and correct. A review of the facility Controlled Drug Key Exchange Audit for the fourth floor front hall nursing unit (Rooms 401 to 408) medication cart revealed that on April 20, 2026, the evening shift off-going nurse failed to sign the controlled substance record to verify the narcotic count was completed and correct. During an interview on April 22, 2026, at 9:10 AM, Employee 2, a Licensed Practical Nurse (LPN), confirmed that the controlled substance records for both the fourth floor front hall medication cart and the fourth floor back hall medication cart were not signed by the off-going nurses on the identified date. During an interview on April 21, 2026, at 12:00 PM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) reviewed the above findings and confirmed the facility did not demonstrate consistent implementation of its policy requiring completion and verification of controlled substance counts at shift change. 28 Pa. Code 211.10(a) Resident Care Policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, clinical records, and staff interviews, it was determined the facility failed to ensure timely physician notification of clinically significant abnormal laboratory results for one of 20 residents reviewed (Resident 87). This deficiency is cited as past non-compliance.Findings include: A review of the facility policy entitled Lab and Diagnostic Testing Clinical Protocol, last reviewed May 20, 2025, indicated the physician will identify, and order diagnostic testing and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing sources will report test results to the facility. When test results are reported to the facility, a nurse will first review the results. Before contacting the physician, the person who is to communicate the results to a physician will gather, review, and organize the information and be prepared to discuss the following: the individuals current condition and details of any recent changes in status (i.e. vital signs and mental status); major diagnoses, allergies, current medications, any recent pertinent lab work; why the lab work and diagnostic tests were obtained; how test results may relate to the individual's current conditions and treatments; and any concerns and questions the physician will be expected to address regarding the resident. Documentation regarding notification will be recorded in the resident's medical record. A review of the clinical record revealed Resident 87 was admitted on [DATE], with diagnoses that included diabetes (a chronic condition affecting the body's ability to regulate blood sugar), dysphagia (difficulty swallowing), and hypokalemia (a condition in which the potassium level in the blood is lower than normal; potassium is an electrolyte that supports heart, muscle, and nerve function). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 14, 2025, revealed that Resident 87 had moderately impaired cognition with a BIMS score of 12 (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 12-15 indicates intact cognition). A review of physician orders dated December 11, 2025, at 6:38 PM, revealed an order for potassium chloride extended-release (a medication used to increase potassium levels in the blood) 20 milliequivalents (mEq) by mouth two times daily, and spironolactone 25 milligrams (mg), a potassium-sparing diuretic (a medication that removes excess fluid while retaining potassium), one time daily related to chronic pulmonary edema (primarily caused by fluid accumulation in the lungs). A review of laboratory results from a complete metabolic panel (CMP, a blood test that evaluates organ function, blood sugar, and electrolyte balance) obtained December 12, 2025, revealed the following abnormal values: Blood Urea Nitrogen (BUN, a test measuring waste products in the blood to assess kidney function): 39 milligrams per deciliter (mg/dL), with a normal range of 6-20 mg/dL (elevated)Creatinine (a blood test used to evaluate kidney function): 1.4 mg/dL, with a normal range of 0.5-1.0 mg/dL (elevated)Estimated Glomerular Filtration Rate (eGFR, a calculation used to determine how well the kidneys filter waste): 37 milliliters per minute (mL/min), with a normal value of greater than or equal to 60 mL/min (reduced kidney function)Potassium (an electrolyte essential for heart and muscle function): 5.2 millimoles per liter (mmol/L), with a normal range of 3.5-5.1 mmol/L (elevated)Chloride (an electrolyte that helps maintain fluid and acid-base balance): 97 mmol/L, with a normal range of 98-107 mmol/L (low)The clinical record failed to reveal documented evidence that licensed nursing staff notified the physician of the above abnormal laboratory results obtained on December 12, 2025, specifically the elevated potassium level in the presence of medications that increase potassium. A review of Resident 87's nursing progress note dated December 14, 2025, at 6:23 PM, revealed the resident's daughter reported the resident was tired and not herself and noted increased confusion. The RN supervisor was notified; however, there was (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no documented evidence that the physician was notified of the prior abnormal laboratory findings or the change in condition. A review of a progress note dated December 15, 2025, at 1:33 PM, revealed the Certified Registered Nurse Practitioner (CRNP) evaluated the resident and ordered repeat laboratory testing for December 16, 2025. A review of a nursing progress note dated December 16, 2025, at 1:34 PM, revealed the laboratory reported a critically high potassium level of 7.4 mmol/L (critical value indicating severe hyperkalemia, which is dangerously high potassium that can cause life-threatening heart rhythm disturbances). The note indicated the resident had increased confusion and complaints of crushing pain at the base of the neck. The physician was notified at that time and ordered immediate transfer to the emergency room. A review of hospital records revealed Resident 87 was admitted with a diagnosis of hyperkalemia (a condition defined as potassium levels above the normal range, which can impair heart function and may lead to cardiac arrest if untreated). A review of the Medication Administration Record (MAR, a legal document that records medications administered to a resident) dated December 11 through December 16, 2025, revealed the resident continued to receive potassium supplementation and spironolactone as ordered despite the elevated potassium level identified on December 12, 2025. During an interview on April 23, 2026, at 10:00 AM, the Director of Nursing confirmed the facility failed to notify the physician of the abnormal potassium level obtained on December 12, 2025, and acknowledged the continued administration of potassium-increasing medications contributed to the critically elevated potassium level on December 16, 2025. This deficiency is cited as past non-compliance. The facility's corrective action plan included the following: All residents' labs and diagnostic studies were reviewed during morning interdisciplinary team meeting and again at stand-down meeting to identify any outstanding labs not followed by the physician and for documentation not in place of notification of the resident's responsible party (RP). To prevent future occurrences, the facility's licensed nursing staff were re-educated on the facility's policies and procedures related to the lab process. To monitor and maintain ongoing compliance, audits will be performed by nursing staff or designee to ensure documentation is completed. The audit will be completed three times per week for four weeks, then weekly for four weeks with results reported monthly to QAPI (Quality Assurance and Performance Improvement, a data-driven framework to maintain and enhance care quality in healthcare facilities) Committee meetings. The facility provided evidence that corrective actions were implemented, including re-education of licensed nursing staff on laboratory review and physician notification requirements, implementation of interdisciplinary laboratory review processes, and initiation of routine audits to ensure compliance. The facility's date of compliance was April 11, 2026. Verification of implementation and ongoing monitoring was confirmed during the survey ending April 24, 2026. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.