STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395346	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onyx Wellness Center	205 East Johnson Highway Norristown, PA 19401

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, drug manufacture's information, interview with resident, and staff interviews, it was determined the facility failed to ensure a newly admitted resident diagnosed with End-Stage Renal Disease (ESRD) and a kidney transplant recipient received life sustaining medication. This failure resulted in the resident missing a total of eight doses of the medication Tacrolimus 0.5 milligrams, which led to critical laboratory values and placed the resident in an Immediate Jeopardy situation of organ rejection for Resident 119. Findings include: Review of the facility's admission policy titled admission Assessment and Follow Up: Role of the Nurse (last revised September 2012), outlines the nurse's role in gathering information about a resident's physical, emotional, cognitive, and psychosocial status at admission. The information is used to begin care planning and complete required assessments, including the Minimum Data Set (MDS- federal mandated assessment tool for all residents). The nurse must greet and assist the resident, ensure comfort, and complete an admission assessment that includes recent medical history, prior hospitalizations, current diagnoses, medications, and treatments. A physical and supplemental assessment must also be conducted. Further review revealed the nurse must reconcile medications using the medication history, admission orders, previous medication administration record (MAR), and discharge summary. Findings are communicated to the attending physician, other departments, and outside services (laboratory or diagnostic services) are notified as needed. Review of the facility's medication reconciliation policy titled, Reconciliation of Medications on Admission (last revised July 2017) revealed it is designed to ensure medication safety when a resident is admitted or readmitted . The process requires staff to create an accurate and complete list of all medications a resident is taking in order to prevent medication errors, omissions, or unintended changes during transitions of care. Preparation includes gathering necessary information such as the approved medication reconciliation form, discharge summary from the referring facility, admission order sheet, prescription and supplement information obtained from the resident, and the most recent medication administration record (MAR) for readmissions. Medication reconciliation involves comparing the resident's medications before discharge with those ordered after admission. The list must include prescription and over-the-counter medications with the drug name, dosage, frequency, route, and indication for use. Continued review of the facility's medication reconciliation policy revealed the purpose of this process is to:Reduce medication errors and improve resident safetyEnsure medications continue without interruption at the correct dose and routeVerify medications are appropriate for the resident's condition and do not cause harmful interactionsEnsure accurate communication of all medications, routes, and dosages to the attending physician and care team The medication reconciliation procedure requires staff to first obtain a complete medication history from the resident, including prescription drugs, over-the-counter medications, herbal supplements, vitamins, patches, eye drops, creams, inhalers, injections, and other treatments. Information collected should include dose, route, frequency, last dose taken, and the reason for use. Residents should also identify all physicians and pharmacies used. Staff must then document all medications on the approved reconciliation form using information from the medication history, discharge summary, (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	previous MAR (if applicable), and admission orders. Finally, the medication list must be reviewed carefully to identify and resolve any discrepancies or conflicts. Review of manufacturer's official prescribing information for the medication Tacrolimus revealed the medication is an immunosuppressant medication used to prevent organ rejection in patients who have received a kidney, liver, or heart transplant. It works by suppressing the immune system, reducing the risk of the body attacking the transplanted organ. In the product monograph it indicates, if a dose is missed, patients should contact their physician or pharmacist for advice and should not try to make up a missed dose on their own. The insert also emphasizes taking Tacrolimus exactly as prescribed and maintaining a consistent dosing schedule to reduce the risk of transplant rejection. Review of the National Kidney Foundation (NKF) article (Immunosuppressant anti-rejection medicines July 24, 2025) revealed, transplant patients must take immunosuppressant medications - including Tacrolimus - exactly as prescribed every day to reduce the risk of organ rejection. Missing even one dose can increase the risk of the immune system beginning to attack the transplanted organ. Continued review of the NKF revealed, missing any Tacrolimus medication doses may result in lower than needed blood levels of the drug, which is strongly associated with an increased risk of organ rejection or graft loss. Even a single missed dose can reduce drug exposure in the blood, although the exact clinical risk varies; consistent nonˆadherence significantly raises the likelihood of rejection. Review of the Resident R119's admission Minimum Data Set (MDS- federally mandated assessment tool used to evaluate resident's clinical status and care needs), dated March 6, 2026, revealed the resident was admitted to the facility on [DATE], from an acute care hospital. The MDS documented diagnoses including Coronary Artery Disease (condition involving narrowing of the heart's arteries that reduces blood flow to the heart); heart failure (chronic condition in which the heart is unable to pump blood effectively); Hypertension (persistently elevated blood pressure that increases the risk of cardiovascular and kidney disease); Peripheral Vascular Disease (circulatory disorder causing reduced blood flow to the extremities); Renal Failure (condition in which the kidneys are unable to adequately filter waste and maintain fluid balance); Diabetes Mellitus (metabolic disorder characterized by elevated blood glucose levels), Acquired Immunodeficiency (indicating a weakened immune system that increases susceptibility to infections); acquired absence of the right leg below the knee and acquired absence of the left leg below the knee (indicating bilateral below-knee amputations); and status post kidney transplant, (resident previously received a donor kidney due to kidney failure and requires ongoing medical management and immunosuppressive therapy). Continued review of Resident R119's MDS assessment revealed the resident was assessed with a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact. Review of Resident R119's hospital records dated February 27, 2026, revealed Resident R119 was a [AGE] year-old with significant past medical history, including End-Stage Renal Disease (ESRD-condition in which the kidneys permanently lose the ability to function adequately and require dialysis or transplantation). Resident R119 is status post renal transplant, meaning he/she received a donor kidney to replace the failed kidney(s). Prior to the transplant he/she required intermittent hemodialysis (treatment that filters waste and excess fluid from the blood using a machine when the kidneys cannot do so); this therapy has since been discontinued following the transplant. Continued review of the hospital records revealed that Resident R119 was a kidney transplant recipient, a condition that requires lifelong management with immunosuppressive therapy and close monitoring of transplant function and medication levels. The resident was prescribed immunosuppressive medications, including Tacrolimus and Mycophenolate, as documented in the medication administration record. These medications are used to suppress the immune response and reduce the risk of rejection of the transplanted kidney. Ongoing administration of these medications is necessary to support continued function of the transplanted organ. Further review of the hospital medication list for Resident R119 revealed the following order: Tacrolimus capsule 0.5 mg - take three capsules (1.5 mg total) by mouth every 12 hours. The discharge documentation indicated the medication was (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	range 3.4-5.3), indicating mild hyperkalemia; chloride 110 mmol/L (reference range 98-107); and COˆ 20 mmol/L (reference range 22-32), suggesting metabolic imbalance. Kidney function studies revealed urea nitrogen (BUN) 70 mg/dL (reference range 8-23) and creatinine 3.24 mg/dL (reference range 0.60-1.50), both significantly elevated, indicating impaired renal function. The BUN/creatinine ratio was 21.6 (reference range 12-20). The estimated glomerular filtration rate (eGFR) was 20 (reference range >59), indicating severely decreased kidney function. Further review of laboratory results revealed Resident R119's Tacrolimus level was reported as <2.0, which is critically below the therapeutic range of 5.0-20.0. These findings are clinically significant because critically low levels of Tacrolimus, combined with abnormal kidney function laboratory values, can place a kidney transplant recipient at significant risk for acute transplant rejection and further deterioration of kidney function. Based on the above findings, Immediate Jeopardy to the health and safety of Resident R119 was identified and revealed to the Nursing Home Administrator and Director of Nursing on March 4, 2026, at 2:00 p.m. Immediate Jeopardy was identified due to the facility's failure to administer the necessary immunosuppressive medication Tacrolimus, which resulted in Resident R119 missing a total of eight doses and experiencing critically low blood medication levels; placing Resident R119 at immediate risk for acute transplant rejection and further deterioration of kidney function. The Nursing Home Administrator was provided with the immediate jeopardy template, and an immediate action plan was requested. On March 4,2026, the facility developed and submitted the following corrective action planResident was admitted on [DATE] with no med reconciliation within 24hour which created a medication omission (Tacrolimus)On 3/2/2026 MD was notified of omission of medication; Per MD resident will start on Tacrolimus 1.5mg q 12 hours on 3/3/2026 after Tacrolimus lab has been obtained.Call placed to resident's nephrologist on 3/2/2026 at 1624 to update on admission to facility and lack of after visit discharge summary received from hospital until today. Residents' medications orders were reviewed with facility physician and order for Tacrolimus was initiated along with labs orderedLab was done on 3/3/2026, and per MD (physician) administer Tacrolimus with same dosage and frequency and continue as prescribed.Results of labs were reviewed by MD on March 4, 2026, ordered to continue the same dose, re-do lab on 3/6/2026 and continue the scheduled follow up with Nephrology on 3/12/2026.The resident was monitored for adverse effects and remained clinically stable. All new admissions and re-admissions will have medication reconciliation reviewed by: Admitting nurse, and, a second licensed nurse within 24 hours of admission.Nurses will be re-educated by UM/designee on: medication reconciliation on new/readmissions and 24-hour audits are to be completedRandom medication administration audits will be conducted to ensure documentation matches administration by DNS/Designee.100% of new admissions and re-admissions will be audited within 24 hours.Random nurses and medication passes will be audited.Any errors identified will result in re-education and corrective counseling.Random Medication administration Audits will be conducted weekly for four weeks, then monthly for 4 months or until substantial compliance is met.Results will be reviewed by the DON and QA Committee.Trends will be tracked and additional education provided as needed.Staff education on admission policy and procedure ongoing will have 90% educated by 3/5/2026 and 100% by 3/6/2026 Review of employee list, facility policy, observations of medication administration pass, and interviews with licensed nurses on medication reconciliation were conducted. Interviews with Licensed nurses' Employee E18, E19, E20, E21, E22, and E22, confirmed they received education on the facility's medication reconciliation process. Interviews with staff demonstrated a thorough understanding of medication reconciliation procedures, including the requirement to reconcile medications upon admission, compare them with new physician orders, and ensure medications are verified and triple-checked for accuracy to prevent omissions. Verification of the implementation of the immediate action plan was completed through review of staff education records and staff interviews. The Immediate Jeopardy was lifted on March 5, 2026, at 4:06 p.m. The Immediate Jeopardy identified for Resident R119 occurred February 27, 2026, to March 4, 2026. 28 Pa. Code 201.14 (a)Responsibility of Licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Code 201.20 (a)(1)(6) Staff development 28 Pa. Code 211.2 (d)(3) Medical Director 28 Pa Code 211.9(2) Pharmacy 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services

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F 0689 Level of Harm - 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 review of clinical records, facility documentation, and interview with staff, it was determined the facility failed to ensure a resident's snack bin was not in a location easily accessible to resident, which resulted in actual harm to Resident R87, while trying to obtain snacks, fell out of bed sustaining a laceration to the head, requiring two sutures and multiple steri-strips for one of two residents reviewed for falls (Resident R87). This deficiency was cited as past non compliance. Findings include: Review of facility policy Fall prevention, dated 2022, revealed the facility will implement fall prevention protocol as determined by resident's needs. Interview the resident and his/her family members to determine any factors that may predispose the resident for fall and/or activities that have helped prevent falls in the home environment. Review of Resident R87's clinical record revealed Resident R87 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (airway disease that restricts breathing), Hemiplegia affecting right dominant side (paralysis on one side of the body), and Cerebral Infarction (blood supply to part of the brain is blocked or reduced). Review of Resident R87's Minimum Data Set assessment (MDS- mandated assessment of a resident's abilities and care needs), dated December 31, 2025, revealed Resident R87 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Review of Resident R87's nursing note, dated July 01, 2025, revealed Approx. 4:15pm this nurse was in hallway when CNA (nurse aide) called me in resident room. Observed resident lying on (his/her) right side inside (his/her) snack box. Resident was reaching for (his/her) snacks. Review of Resident R87's care plan, (revised August 01, 2020) revealed Resident R87 is at risk for falls or fall related injury. Further review of Resident R87's care plan revealed an intervention, (initiated July 02, 2025) instructing staff to remove snack bin out of resident's sight and reach. Review of Resident R87's nursing note, dated February 07, 2026, revealed Resident R87 was found lying on floor on top of leg rests and snack bucket next to (his/her) bed by staff. Three lacerations to right side of head were noted. Review of facility investigation, dated February 07, 2026, revealed staff observed Resident R87 lying on the floor with (his/her) head on the floor and (his/her) legs in snack bin. Resident R87 was found to have three lacerations to (his/her) head. Lacerations measuring 4 long x 1/4 wide; 2 1/2 long x 1/4 wide; 1 long x 1/4 wide. At approx. 5:00 a.m. the nurse assistant provided Resident R87 with something to eat and drink at the resident's request from the snack bin. At 6:30 a.m. the resident attempted to lean over in bed and get himself another snack from the snack bin which was located next to Resident R87's bed triggering resident to roll off the bed onto the floor. Resident R87 was sent to emergency department of evaluation. The resident returned to the facility with two sutures and multiple steri- strips (thin bandages often used by surgeons as backup to dissolvable stiches). Review of witness statement, by nursing assistant, Employee E27, revealed Employee E27, observed Resident R87 on the floor inside (his/her) snack bin. Nurse aide, Employee E27, then moved the bed and nightstand to get to the resident, as well as lowered the bed. There was blood observed to the right side of Resident R87's head. Review of nurse aide witness statement, Employee E28, revealed she refilled the resident's snack bin then placed the bin back where she found it, under the bed on right side by the headboard. Interview on February 04, 2026, at 1:45 p.m. with Director of Nursing, Employee E2, confirmed Resident R87 fell out of bed while attempting to reach for snack bin under his/her bed. This deficiency was identified as actual harm past non-compliance for failure to ensure that Resident R87's snack bin was not in a location easily accessible to Resident R87, who reached for more snacks, fell out of bed and sustained a laceration to the head, requiring two sutures and multiple steri- strips.The facility presented documentation indicating that the facility initiated a plan of correction February 7, 2026. The facility plan of correction included the following:-Resident R87 will have (his/her) snacks removed from (his/her) room and placed in Unit's Manager's office. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident's daughter notified, plan of care updated.-Audit conducted to ensure that no other resident has intervention not keep snacks within reach of resident.-If resident has intervention to keep snacks out of reach of resident; staff will remove snacks; notify responsible party; place in area where snacks can be retrived for resident; update residents's plan of care.Education provided to staff to remove snacks from resident's room that can not manage snacks themselves.Results of the audits will be presented to QAPI (Quality Performance Improvement Plan) committee for review and recommendations to adjust, increase/decreasefrquency or update plan. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure residents' advance directives and physician orders for Life-Sustaining Treatment (POLST) were followed according to the residents' expressed wishes for 2 of 2 residents reviewed with advance directives. Resident R116 and R121)Findings include: Review of the facility's Advance Directives Policy dated December 19, 2022, indicated the facility is responsible for respecting residents' rights to participate in medical decision-making and to exercise self-determination regarding their care. The policy states that residents will be informed of their right to accept or refuse medical or surgical treatment and to create an advance directive in accordance with the Patient Self-Determination Act (PSDA) and state law. The facility will provide written information about advance directives upon admission, or to the resident's representative if the resident is incapacitated. The policy further states that care will not be conditioned or withheld based on whether a resident has an advance directive. Any advance directive must be maintained in the resident's medical record, and admission staff must document whether the resident has an advance directive and that information regarding advance directives was provided during the admission process. If a resident expresses a desire to revise a prior advance directive, the change must be documented and a revised directive submitted in accordance with applicable regulations. Review of the Pennsylvania POLST (Physician Orders for Life-Sustaining Treatment) is a medical order designed to ensure that a patient's treatment preferences, including life-sustaining interventions and comfort measures, are clearly documented and followed across healthcare settings. At the time the POLST is completed, any existing advance directives must be reviewed. The form must be signed by a physician and the patient or authorized surrogate, though verbal physician orders are acceptable if followed by a physician signature per facility policy. If the patient's condition changes, the patient or surrogate must be contacted to update the POLST. Oral fluids and nutrition should be offered when medically feasible, and comfort measures must be provided in an appropriate setting. Patients or authorized surrogates may revoke or modify any part of the POLST at any time, including withholding or withdrawing life-sustaining treatment. The POLST should be reviewed periodically, and if it becomes invalid or is replaced, the previous form must be voided by marking through sections A-E and writing VOID across the form. If any section is incomplete, providers should follow other appropriate methods to determine treatment preferences. Review of Resident R 116's POLST (Physician Orders for Life-Sustaining Treatment) revealed that the resident elected DNR (Do Not Resuscitate), Do Not Attempt Resuscitation and DNH (Do Not Hospitalize) when not in cardiopulmonary arrest, with a focus on comfort measures only. Orders include the use of medications by any route, positioning, wound care, and other interventions to relieve pain and suffering. Oxygen, oral suction, and manual treatment of airway obstruction may be used as needed for comfort. Resident R 116 is not to be transferred for life-sustaining treatment but may be transferred if comfort needs cannot be met in the current location. Review of Part C (Antibiotics) indicates that antibiotics may be used only if life can be prolonged. Review of Part D (Artificially Administered Hydration/Nutrition) indicates that oral fluids and nutrition should be offered if feasible, but Resident R116 has elected no artificial hydration or nutrition by tube. The form was signed by the physician, the resident, and a registered nurse on August 9, 2021, acknowledging that the orders reflect the resident's known desires and best interests. Review of Resident R 116's Minimum Data Set (MDS- federal mandated assessment tool) dated June 30, 2025, revealed the resident had been residing in the facility since 2021. The resident scored 9 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Documented diagnoses included cerebrovascular accident (stroke- a condition caused by interrupted blood flow to the brain resulting in neurological impairment); diabetes mellitus (failure of the body to (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	produce insulin); and hyperlipidemia (a condition characterized by elevated levels of fats or cholesterol in the blood, which increases the risk of cardiovascular disease). Review of the Resident R116's care plan revealed a focus area addressing advance directives. The care plan indicated the resident's code status as Do Not Resuscitate (DNR), Do Not Intubate (DNI), and Do Not Hospitalize (DNH) with comfort measures only. The care plan directed staff to refer to the resident's POLST form for specific medical orders. Review of the POLST indicated it was initiated on February 16, 2022, and revised on July 22, 2025. Interventions included that the resident's physician would periodically review the POLST form and the resident's code status during routine visits with the resident. Review of Resident R 116's nursing notes dated January 3, 2026, at 2:46 PM, the resident was febrile and monitored for cold-like symptoms. On January 5, 2026, at 6:59 PM, nursing observed increased respiratory effort, diminished breath sounds, wheezing, elevated blood pressure (183/96 mmHg), temperature 103.7 Fahrenhiet, and heart rate 114 bpm (beats per minute). The physician was notified. Continued review of nursing notes dated January 6, 2026, at 11:19 AM, the physician evaluated the resident in-house, new orders were received for immediate blood work and the resident's representative was notified and updated regarding the plan of care. Laboratory results later showed sodium 157 mmol/L, and the physician on call was contacted; the resident representative was again notified. On January 7, 2026, at 10:27 AM, laboratory results and chest X-ray results were reviewed. The chest X-ray showed early changes suggestive of pneumonia, slightly worse than prior imaging. New orders for IV (intravenous) fluids and repeat BMP were implemented. The resident representative was informed of the findings and interventions, including the plan to normalize sodium levels. On January 8, 2026, at 11:44 AM, the Social Services Department notified the Director of Nursing that the resident's guardian had changed the code status to full code. The resident had a previously signed POLST indicating DNR (do not resuscitate/DNI (do no intubate)/DNH (do not hospitalize) with comfort measures only, signed prior to guardianship. The physician assistant was notified, and resident was sent to the hospital. Interview with Social Worker, Employee E6, on March 5, 2026, at 1:00 PM, she reported that she called the resident's guardian, who instructed her via phone to change the resident's code status to full code. She immediately notified the nursing department of the guardian's request. The social worker Employee E6 acknowledged that she acted on the guardian's verbal instruction without obtaining proper documentation, verifying authority, or ensuring a physician-signed POLST update. She also stated she believed there were two POLST forms in the resident's chart but was unable to provide or locate the second form. The resident's guardian stated he has another POLST but was unable to provide it. He acknowledged that the POLST in the resident's clinical record was signed by the resident prior to guardianship and that after becoming guardian, he instructed the facility to change the POLST to full code, but no signed or documented POLST exists in the chart. The guardian claimed he had authority to change the resident's code status based on verbal conversations with the resident. Review of the clinical record revealed that the resident's representative was notified throughout the resident's decline, but no code status change was documented until the physician assistant sent the resident to the ER, and there is no written record of the POLST change. Review of Resident R121's clinical record revealed Resident R121 was admitted to the facility on [DATE] with a diagnosis of heart failure (condition where the heart muscle can't pump blood as well as it should), protein calorie malnutrition (happens when you are not consuming enough protein and calories), and cerebral infarct (also known as an ischemic stroke, is the death of brain tissue due to lack of blood flow). Review of Resident R121's Minimum Data Set (MDS- mandated assessment of a resident's abilities and care needs), dated August 25, 2025 revealed Resident R121 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Review of Resident R121's POLST (Portable Orders for Life Sustaining Treatment), signed August 25, 2025, revealed Resident R121 and RR (resident representative) discussed/elected DNR (Do Not Resuscitate), Do Not Attempt Resuscitation, and DNH (Do Not Hospitalize). When not in cardiopulmonary arrest, resident elected for comfort measures only, which include the use of (continued on next page)

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	395346	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onyx Wellness Center	205 East Johnson Highway Norristown, PA 19401

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications by any route, positioning, wound care, and other interventions to relieve pain and suffering. Oxygen, oral suction, and manual treatment of airway obstruction may be used as needed for comfort. The resident is not to be transferred for life-sustaining treatment but may be transferred if comfort needs cannot be met in the current location. Review of facility investigation, dated August 31, 2025, revealed on August 31, 2025 Resident R121 was found in his/her room on the floor. Resident R121 was laying on right side with head at foot of bed. Resident R121 was noted to have hematoma on right side of head and nose area. The nurse then called 911 to have Resident R121 evaluated at the emergency room (ER). Further review of facility investigation revealed agency nurse did not follow resident's POLST for DNR/DNI/DNH and did not obtain an order to have resident sent to ER for further evaluation. Agency nurse called 911 and left voicemail to office . Resident was at the facility on comfort measures only and was made DNR/DNI/DNH signing a POLST form on 8/25/2025. Interview on March 05, 2026 at 11:35 p.m. with Director of Nursing, Employee E2, confirmed Resident R121's POLST was not followed on August 31, 2025. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa Code 211.2 (d)(7) Medical Director 28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interviews with residents and staff, it was determined that the facility did not ensure a baseline care plan was developed within 48 hours of admission related to dementia care for one of 22 residents reviewed. (Resident R9) Findings Include: Review of Resident 9's clinical records revealed Resident R9 was admitted to the facility on [DATE] with diagnoses that included but were not limited to Dementia (progressive disease characterized by impaired memory, thinking and behavior that affects ability to perform daily tasks), bipolar disorder (mood disorder marked by extremes in feelings of elation or depression), cerebral ischemia (lack of blood flow to brain causing damage or death to brain tissue), chronic obstructive pulmonary disease (COPD, a progressive lung disease causing breathing difficulties), and difficulty in walking. Review of Resident R9's clinical record revealed Resident R9 had a care plan dated January 15, 2026, that included interventions related to focus areas of potential for discomfort/side effects related to use of psychotropic medications, alterations of respiratory status, COPD (chronic obstructive pulmonary disease), and interventions pertaining to risk for falls. Further review of Resident R9's care plan revealed no interventions in place to provide the necessary care to properly care for Resident R9's dementia care needs. Interview with Employee E2, Director of Nursing, on March 5, 2026, at approximately 1:00 PM confirmed no care plan was in place related to Resident R9's dementia care needs. 28 Pa. Code 211.10(d) Resident care policies

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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 review of facility policy, observations and interviews with staff, it was determined that the facility failed to ensure that residents were provided appropriate supervision while dining for 6 of 6 residents observed. (Resident R60, R92, R58, R94, R101, and R39) Findings include: Review of facility policy titled Dining Service (dated 12/19/2022) requires that all residents receive a nourishing, balanced diet served in accordance with their preferences. Staff are responsible for validating meal accuracy, assisting with meal service, monitoring residents during meals, and responding to resident needs. Trays must not be left unattended, and residents must have adequate time and support to safely complete their meals. Observations on March 5, 2026, at 08:35, revealed Residents R60, R92, R58, R94, R101, and R39 were observed in the first-floor dining area without assigned supervision. One resident made choking/grunting noises. Licensed nurse Employee E25 intervened after noticing the resident, stating that residents should not be left alone. Interview with Nursing Assistant Employee E26 who immediately came into the room, when asked about assignment, stated she was unaware she was scheduled to monitor the dining area. Interview with the DON Employee E2 confirmed on March 5, 2026 at 10:40 a.m. that it is facility protocol for nursing staff to monitor residents during all meals and that residents should never be left unattended while eating. 28 Pa. Code 211.12 (d)(7) Nursing Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, it was determined that the facility failed to ensure safe and sanitary food storage practices on four of the facility's four nursing units. Findings include:Review of facility nutrition services practice manual food policies titled Storage dry Storage revealed store perishable foods in the refrigerator and or foods kept refrigerated by the manufacturer maintain refrigerator temperatures at thirty-four thirty-eight degrees storable meat away from vegetables and cooked foods label products with delivery date including month and year the product was received store leftover foods and container which are shallow to facilitate cooling impervious and dishwasher safe label all leftovers with recipe name and date of storage discard refrigerator leftovers after seventy-two hours cover all pre-dish items with plastic wrapper foil to prevent all flavors drying and or cross-contamination A review of the facility's Nutrition Services Practice Manual, under Food Storage and Dry Storage Policies, revealed the following requirements:Perishable foods must be stored in the refrigerator or units and kept at manufacturer-recommended temperatures, with refrigerators maintained between 34-38 F.Raw meats must be stored separately from vegetables and cooked foods to prevent cross-contamination.All products must be labeled with the delivery date, including month and year of receipt.Leftover foods must be stored in shallow containers to facilitate cooling, and containers must be impervious, dishwasher safe, and labeled with the recipe name and date of storage.Refrigerator leftovers must be discarded after 72 hours.All pre-dish items must be covered with plastic wrap or foil to prevent flavor transfer, drying, and cross-contamination. During the initial tour of the facility kitchen on March 2, 2026, at 9:30 AM, several food storage concerns were observed. Sour cream and salsa containers did not have a date indicating when they were opened or received. Coleslaw dressing and relish were also observed without date labeling. A container of PAM cooking spray, received on February 25, 2026, was not labeled with an open or use date. In addition, a pan of diced chicken prepared for chicken salad intended for use that evening did not have a preparation or use date. Three trays of Jell-O were observed uncovered and without date labeling. Containers of applesauce and sliced apples were also not dated. A container of jelly was dated February 21, which exceeded the seven-day storage guideline per facility policy and should have been discarded. Observation of the dry storage area revealed that rice and flour bins contained scoops left inside the bins, which may pose a risk for contamination. An interview was conducted with the Food Service Director (Employee E9) at the time of the above observations. The Food Service Director confirmed the observations, acknowledging that several food items were not properly dated or covered in accordance with facility policy. 28 Pa Code 201.18(b)(1) Management28 Pa. Code 211.6(f) Dietary Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policies, job descriptions, medication documentation, and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and Director of Nursing (DON) failed to effectively manage the facility to ensure that a newly admitted resident diagnosed with End-Stage Renal Disease (ESRD) and a kidney transplant recipient received life sustaining medication. This failure resulted in a resident missing a critical immunosuppressive medication and placing the resident an Immediate Jeopardy situation. (Resident 119) Findings include: Review of The Director of Nursing (DON)'s job description revealed that the DON is responsible for the overall planning, coordination, and supervision of nursing services, including ensuring that nursing staff perform accurate admission assessments, medication reconciliation, and timely administration of physician-ordered medications. The DON is expected to oversee staff performance, implement clinical policies, monitor compliance with federal, state, and local regulations, and facilitate interdisciplinary communication among physicians, therapists, and support personnel. This role requires the DON to make independent clinical decisions, respond to emergencies, and maintain systems that protect resident safety and quality of care. Review of the Nursing Home Administrator (NHA)'s job description revealed that the NHA is responsible for the overall operation of the facility, including ensuring compliance with all regulatory requirements, implementing operational policies, managing staffing, and overseeing coordination among departments. The NHA must ensure that systems are in place to provide safe and effective care, supervise leadership staff including the DON, address deficiencies in clinical practice, and maintain accountability for facility-wide adherence to policies and procedures. The NHA also serves as the primary liaison with regulatory agencies, residents, families, and the public, ensuring that resident safety and quality of care remain the facility's top priority. Review of the facility's policies, including admission Assessment and Follow Up: Role of the Nurse and Reconciliation of Medications on Admission, requires that nursing staff obtain a complete medication history, reconcile medications with hospital discharge summaries, previous MARs, and physician orders, and ensure critical medications are administered promptly. These policies are essential to prevent medication omissions, ensure continuity of care, and protect residents from harm. Review of Resident R119's clinical record revealed that the resident was a kidney transplant recipient. The resident was admitted to the facility on [DATE] with orders to continue Tacrolimus 1.5 milligrams (mg) by mouth every 12 hours, a critical immunosuppressant medication necessary to prevent organ rejection. Review of the Medication Administration Record (MAR) and interviews revealed that there was no order for the medication Tacrolimus entered upon admission, and the resident did not receive the medication from February 27 through March 3, 2026, missing a total of eight doses. Review of laboratory results obtained on March 3, 2026, revealed critically low Tacrolimus level of <2.0 ng/mL, significantly below the therapeutic range, placing the resident at immediate risk for transplant rejection and kidney failure. Based on the deficiencies cited in this report, the NHA and DON failed to ensure the essential functions and duties of their position, contributing to an Immediate Jeopardy situation. Refer to F760 28 Pa. Code 210.14(a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.20 (a)(1)(6) Staff development28 Pa Code 211.12 ((c)(d)(1)(3)(5) Nursing Services