STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395359	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jersey Shore Skilled Nursing and Rehabilitation Ce	1008 Thompson Street Jersey Shore, PA 17740

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on clinical record review and staff interview, it was determined that the facility failed to provide physician ordered treatment for wounds for four of five residents reviewed (Residents CR1, 1, 2, and 4). Findings include: Clinical record review for Resident 1 revealed a physician's order dated July 26, 2025, for the resident to have treatment to a Stage 3 (full thickness skin loss that extends to the fat layer) of the right heel daily cleansing with a normal saline solution (NSS), pat dry, apply skin prep to the wound and leave open to air. There was no evidence this treatment was completed on September 11, and 17, 2025. Closed clinical record review for Resident CR1 revealed a physician's order dated August 25, 2025, for the resident to have a left lateral foot wound cleaned with NSS and have a betadine (antiseptic) soaked cover, pads, and gauze applied and covered with a bandage wrap every three days. The resident also had an order dated August 25, 2025, to receive treatment to venous ulcers (due to poor circulation) on his right foot first toe, left foot third toe, and the left heel to cleanse with NSS, paint with betadine, leave open to air, and to be done daily. Review of Resident CR1's treatment record for August 2025, revealed the resident was not documented as receiving the treatment on August 31, 2025, as ordered/scheduled. Clinical record review for Resident 2 revealed a physician's order dated September 19, 2025, for the resident to have treatment with negative pressure wound therapy (a vacuum to remove fluid and debris from wounds to promote healing) continuously, with a treatment to include the wound cleansed with wound cleanser, gauze placed into the wound, apply skin prep to intact skin around the wound, apply a dressing and secure the vacuum tubing per the manufacturer's guidelines every Monday, Wednesday, and Friday. Review of Resident 2's treatment record for September 2025, revealed the resident was not documented as receiving the treatment as ordered on Friday, September 26, 2025. Clinical record review for Resident 4 revealed a physician's order dated September 10, 2025, for the resident to have treatment completed to a pressure ulcer (wound of the skin due to prolonged pressure to an area) on the resident's coccyx to be cleansed with normal saline and apply calcium alginate (cream used for wound treatment), and cover with foam dressing every day. Review of Resident 4's treatment record for September 2025, revealed no evidence that the resident received the treatment as ordered on September 15, 19, 22, 29, 30, 2025. Further review for Resident 4 revealed a physician's order dated September 8, 2025, for negative pressure wound therapy continuously to the resident's left hip with a treatment to the wound itself including cleansing the wound with cleanser, placing foam into the wound, covering the wound with a dressing, and securing the wound vacuum tube every Monday, Wednesday, and Friday. Review of the resident's treatment record for September 2025, revealed no evidence the treatment was completed as ordered on September 15, 19, 22, or 29, 2025. A nursing note dated September 30, 2025, at 5:17 PM noted the resident's wound vacuum had been alerting full canister from the start of shift and the resident indicated the wound nurse came to his room that morning to change it but didn't have the supplies and was told the wound nurse had to order the supplies. The information regarding no evidence of the above noted treatments was reviewed with the Director of Nursing and Nursing Home Administrator on October 1, 2025, at 3:30 PM. There was no additional information to indicate whether the treatments were completed as ordered or that the resident had refused or was not available for the treatment to be completed. The Director of Nursing indicated Resident 4 utilized a different negative pressure machine for his wound than others in the facility and supply delivery was delayed, which may have impacted Resident 4's treatments. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies, clinical record review, and resident and staff interview, it was determined that the facility failed to provide timely medications to one of five residents reviewed (Resident 3) and failed to obtain and provide medications for one of five residents reviewed (Resident CR1). Findings include: Review of the facility's current policy entitled Medication Administration General Guidelines, revealed it is the facility's policy that medications are administered within 60 minutes of scheduled times, except before or after meal orders, which are administered based on mealtimes. In an interview with Resident 3 on October 1, 2025, at 3:14 PM the resident indicated she sometimes needs to tell staff she needs her medications because they are late. Resident 3 stated she used to get her morning medication closer to 8:00 AM but it has been closer to 10:30 AM at times, and that she believes her medication times were going to change because staff were working on two floors. Review of Resident 3's medication administration record for September 2025, revealed the following medications administered outside the 60-minute window of the scheduled administration time. Breo Ellipta Inhalation Aerosol Powder (a maintenance medication to assist with breathing conditions) scheduled for 8:00 AM was administered late between 10:00 and 11:00 AM on September 26, 27, 28, and 29, 2025. Diltiazem HCL Extended Release (used to treat blood pressure) scheduled for 8:00 AM was administered late between 10:00 and 11:00 AM on September 26, 27, 28, and 29, 2025. This medication was also ordered to be held for the resident for a systolic blood pressure (top/upper number, pressure when your heart beats) less that 90, and a heart rate less than 50. There was no evidence that Resident 3's blood pressure or heart rate was checked prior to the administration of this medication on September 27, 28, 29 or 30, 2025. Eliquis (blood thinner) scheduled for administration two times a day at 8:00 AM and 8:00 PM was administered late between 10:00 and 11:00 AM on September 26, 27, 28, and 29, 2025, and too early for the second dose between 5:00 PM and 6:00 PM on the same days the morning dose was administered late on September 26, 27, and 28, 2025. The resident was not documented as being administered, the evening dose on September 29, or the morning or evening dose on September 30, 2025. There was no evidence to indicate the resident refused or was not available for staff to administer the medication. Metoprolol Succinate Extended Release (blood pressure and heart medication) scheduled to be given one time a day at 8:00 AM was administered late between 10:00 and 11:00 AM on September 26, 27, 28, 29, 2025. The medication was also ordered to be held for a systolic blood pressure less than 90 and a heart rate less than 50. There was no evidence that Resident 3's blood pressure or heart rate was checked prior to the administration of this medication on September 27, 28, 29 or 30, 2025. Potassium Chloride Extended Release (mineral supplement to maintain fluid balance and heart and kidney function) scheduled to me administered three times a day at 6:00 AM, 2:00 PM, and 8:00 PM was not documented as administered for the 6:00 AM dose on September 16, and 24, and late between 9:00 AM and 10:00 AM on September 30th, 10:00 and 11:00 AM on September 26, 27, 28, 29, 2025. Resident 3 was then documented as receiving the next dose of the extended-release medication within the scheduled time of 1:00 PM - 3:00 PM (one hour before/after scheduled 2:00 PM) potentially leaving only 4 hours between doses. Tylenol (mild pain reliever) scheduled to be administered two times a day at 8:00 AM and 8:00 PM was administered late between 10:00 and 11:00 AM on September 26, 27, 28, 29, 2025, and the evening dose was documented as being administered early between 5:00 and 6:00 PM on September 26, 27, and 28, 2025, three of the same days the morning dose was administered late. The resident was not documented as being administered, the evening dose on September 29, or the morning or evening dose on September 30, 2025. There was no evidence to indicate the resident refused or was not available for staff to administer the medication. In an interview with the Director of Nursing on October 1, 2025, at 2:30 PM she indicated Resident 3 is permitted to self-administer medications, but the time documented on the Medication Administration Record would be the time staff provided the resident with the medication. Closed clinical record review for Resident CR1 revealed the resident was re-admitted to the facility on [DATE], from the hospital where the resident was being treated for a wound of the left foot and returned to the facility with a PICC line (flexible tube inserted into a vein used for long-term intravenous medication administration). A facility physician history and physical note dated August 22, 2025, at 8:02 PM indicated that Resident CR1 was admitted and treated at the hospital for a left foot abscess, and was discharged from the hospital with Levofloxacin (potent, broad-spectrum antibiotic used to treat bacterial infections), 750 milligrams to be given