STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395370	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Woods Nursing and Rehabilitation Center	313 County Line Road Hatboro, PA 19040

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy and interview with staff, it was determined that the facility failed to conduct a complete and through investigation for an allegation of missing potential narcotic medication for 1 out of 2 residents reviewed (Resident R2). Findings include:Review of the facility policy, Discrepancies, Loss and/or Diversion of Medications, with a effected date of September 2018 indicated that All discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. A review of the physician note dated October 15, 2025, stated [Resident R3] has chronic headaches that are well controlled. [Resident R2] has not used oxycodone for the past few months and does not wish to take Mucinex. [Resident R2] feels well with no current headache concerns. Medication was discontinued on October 15, 2025. A review of Resident R2's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis of chronic pain syndrome. A review of the Medication Administration Report (MAR) for October 2025 indicated a physician order on August 9, 2024, oxycodone give 5 mg by mouth every 4 hours as needed for pain related to migraine with aura intractable with status migraineurs. Based on October 2025 MAR Resident R2 marked as received the medication on: October 3, 2025, at 12:10AM and 5:55 AM by Licensed nurse, Employee E5 October 7, 2025, at 5:55 AM, by Licensed nurse, Employee E5 October 8, at 1:35 AM am 6:03 AM, by Licensed nurse, Employee E5 October 12, at 05:38 AM, by Licensed nurse, Employee E5 October 13, at 1:56 a.m. am 6:16 AM, by Licensed nurse, Employee E5Review of Controlled Substance Inventory Count Sheets for Resident R2 revealed that the medication oxycodone was signed off by the license nurse, Employee E5 on October 8, 9, 11, 12, 13, 2025. Showing medication discrepancies on October 9 and 11, 2025. An interview with the unit manager, Employee E4, on November 3, 2025, at 11:10 a.m. revealed that Resident R2 was alert and oriented. When Resident R2 stated that he/she had not requested the medication on October 15, 2025, the facility suspected a possible diversion of medication. Employee E4 reviewed the narcotic book and found that Employee E5 was the only staff member signing out the medication; no other nurse had signed for it. Additionally, after reviewing the Medication Administration Record (MAR), Employee E4 identified a discrepancy between what was documented in the narcotic book and what was signed off in the MAR. Employee E4 reported the allegation of medication diversion to the Director of Nursing, Employee E2, on October 15, 2025, when the physician discontinued the medication.An interview with the Director of Nursing on November 3, 2025, at 11:15 a.m. revealed that the Unit Manager, Employee E4, had notified her of the suspected narcotic diversion on October 15, 2025, involving Licensed Nurse, Employee E5. The Director of Nursing stated that because the Administrator, Employee E1, was out of the office and Licensed nurse, Employee E5 was not scheduled to return until October 21, 2025, the facility did not initiate an investigation into the suspected diversion at that time. On October 22, 2025, the facility received another allegation of medication diversion involving Resident R3 by the same Licensed Nurse, and an investigation was initiated. On the same day, at 12:08 p.m., the Director of Nursing confirmed that the facility did not investigate when the initial suspicion of medication diversion arose on October 15, 2025.28 Pa. Code 201.14(a)(e) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 201.29(c) Resident rights28 Pa. Code 211.10(d) Resident care policies

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and documentation, and interviews with staff, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of one residents reviewed for elopement risk (Resident R1). Findings include:Review of facility policy titled, Elopement/Seeking Behaviors, dated January 29, 2024, revealed, upon admission to the center, each patient will be assessed for elopement/exit seeking history and/or behaviors using the elopement Risk Tool Assessment.Review of Resident R1's clinical records revealed that Resident R1 was admitted to the facility on [DATE], with diagnosis including Alzheimer's Disease and had a BIMS score of five, indicating moderate cognitive impairment. Further review of Resident R1's Elopement Risk evaluation, dated October 5, 2025, revealed a score of one, indicating low risk for elopement. Review of Resident R1's care plan, date-initiated September 19, 2025, revealed that the resident is at risk for elopement related to dementia and had a wander prevention band to front walker.Review of incident report dated on October 27, 2025, revealed that on October 26, 2025, the receptionist hit the lock release button on the front door which allowed multiple visitors along with [Resident R1] to go through the entrance. [Resident R1's] wander guard alarmed when she re-entered the building. Review of undated witness statement by the Nurse Aide, Employee E3 revealed, [Employee E4] told me to run there is a resident left the building. She is in the parking lot. So I ran to the front door and the parking lot . I kept going to the road . when I got there, the resident was on the left side by the pool parking lot. Interview with the Director of Nursing, conducted on November 3, 2025, at 10:48 a.m. revealed that the incident occurred on October 26, 2025, at approximately 5:41p.m. and the resident had been located by Nurse Aide, Employee E3, on October 26, 2025, at approximately 5:44p.m.28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.10 (d) Resident Care Policies.28 Pa. Code 211.12 (d)(5) Nursing Services.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that drug records are in order and that an account of all controlled drugs is maintained and reconciled for two out of two residents reviewed. (R2, R3)Findings include:Review of facility policy, Storage of Controlled Substances dated 2025, revealed, Medication classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations . Review of facility submitted documentation to the state survey office via Event Reporting System (ERS) on October 23, 2025, a misappropriation of patient property reporting that on October 22, 2025, the license nurse, Employee E5 did a narcotic count at the end of her shift with oncoming nurse, Employee E6. Everything seemed good until oncoming license nurse, Employee E6 noticed that on the PRN Oxycodone sheet later in the morning that the count went from 14 to 12 with only 1 table being signed out. It also looked like that resident, who has been asking for her PRN Oxycodone less and less, received 3 doses during the night shift. Oncoming license nurse, Employee E6 asked Resident R3 how many she had requested her PRN oxycodone during the night shift, and the resident RR3 answered that she had not asked for it at all. Director of nursing called Employee E5 to come in for an interview, During the interview, Employee E5 admitted to taking oxycodone. Employee E5 was immediately suspended pending the outcome of an investigation. At no time was this resident, or any other, without pain medication either related to the diversion or not. A report was made to the Hersham Policy Department, and a complaint was made to the PA Nursing Licensing Board . A review of the internal investigation a written statement written on October 22, 2025, by the Administrator, Employee E1 revealed on October 22 it was brought to my attention that there has been a discrepancy with an oxycodone narcotic count on B Wing. The first issue involved a male Resident R2, who had PRN Oxycodone 5 mg ordered. The med was DCD on 10/15/2025 after the resident stated to his physician that he had not taken it in almost 2 months. It was noted that [NAME] had signed it out seven times during her night shift to administer it to him. This involved 7 doses. When this was discussed with Employee E5 she insisted she had given it to him because he had asked for it. At this time, there was no reason to believe that Employee E5 had diverted the medication. The second issue occurred in the morning of October 22, 2025. It was noted that Employee E5 had signed out PRN Oxycodone 10 mg 2x for a different Resident R3, to find out how many times she had asked for the oxy during the night shift. Resident R3 shard that she had not requested it at all. At his time, we reached out to Employee E5 and asked her to come in for a meeting. The meeting occurred at approximately 4:15 p, Unit Manager, Employee E4, Director of Nursing (DON), Employee E2 and Administrator, Employed E1 were in attendance with Employee E5. DON explained to Employee E5 that they were dealing with a narcotic medication issue. Employee E5 first asked her again about Resident R2 and his sharing that he had not asked for oxycodone for almost 2 months. Employee E5 reiterated that she had absolutely given it to him. Then DON, E2 shared that there also now had been a discrepancy in Resident ' R3 narcotic count that very morning. Employee E appeared to be very nervous at this time. Employee E1 to her that we would be taking her to a drug test. She immediately stated that she was agreeable. Then she hesitated and told us that we would find marijuana in her system. DON, E2 and Admin, E1 both told her that they were not looking for marijuana, be were looking specifically for oxycodone. At this point E5 became distraught and started shaking. E5 looked back and forth to each of us and stated that yes, she had taken the medications .DON, E2 then asked her if she had taken the medication for herself. E5 replied, I already admitted it, please don ' t ask me to say more. I am so ashamed . A written statement completed on October 23, 2025, by the DON, E2 revealed, [unit manager, E4] informed me that there was a narcotic discrepancy on B wing from night shift to day shift. She was informed by day [licensed nurse E6] who stated she counted the narcotics with [license nurse, Employee E5] from night shift and all seemed find until she was reviewing narcotic sheets later in her shift, she noticed that the count went from 14 to 12 on one the PRN Oxycodone sheets with only 1 table being signed out. On investigation, the nurse signed out the narcotic for 3 doses during the night shift: not according to the physician order. Upon investigation of the narcotic book that is assigned to [licnsed nurse, Employee E4] on her shift, it was noted that another resident had been given his PRN oxycodone medication regularly by [licensed nurse, Employee E4] for the month of October up until 10/15 when the medication was discontinued by the attending as the resident had stated to him that he

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of facility's policy and the review of clinical records, it was determined that the facility failed to ensure that complete and accurate documentation for one of one resident reviewed for elopment risk (Resident R1).Findings include:Review of facility policy titled, Elopement/Seeking Behaviors, dated January 29, 2024, revealed, upon admission to the center, each patient will be assessed for elopement/exit seeking history and/or behaviors using the elopement Risk Tool Assessment.Review of Resident R1 clinical records revealed That Resident R1 was admitted to the facility on [DATE], with diagnosis including Alzheimer ' s Disease and had a BIMS score of five, indicating moderate cognitive impairment.Further review of Resident R1 ' s Elopement Risk evaluation, dated October 5, 2025, revealed a score of one, indicating low risk for elopement. Review of Resident R1 ' s care plan, date-initiated September 19, 2025, revealed that the resident is at risk for elopement related to dementia and had a wander prevention band to front walker. Continued review of the Elopement Evaluation Assessment tool, dated October 5, 2025, indicated that Resident R1 had no diagnosis of dementia/cognitive impairment. Interview with Licensed Practical Nurse, Employee E4, conducted on November 3, 2025, at 11:36 a.m. confirmed that Resident R1 has a standing diagnosis of Alzheimer ' s dementia and is cognitively impaired. Further interview confirmed Section F titled, Diagnosis ' , was coded incorrectly. 28 Pa Code 211.12(c) Nursing services