STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395371	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Apollo	151 Goodview Drive Apollo, PA 15613

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on facility policy, observation and staff interview, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for one of four residents (Resident R25). Findings include: Review of facility policy Indwelling Urinary Catheter dated 4/17/25, indicated the catheter bag should have a privacy cover applied at all times unless it has one built in by the manufacturer. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of Resident R25's care plan dated 6/19/24, indicated the resident has an indwelling urinary catheter with an intervention of position catheter bag and tubing below the level of my bladder, without kinks, and secured with a leg strap - facing away from the entrance to my room. During an observation on 5/19/25, at 10:07 a.m. Resident R25's catheter draining bag was observed hanging on the right side of the resident's bed, facing the entrance of the room, and without a privacy cover applied. During an interview on 5/19/25, at 12:48 p.m. Licensed Practical Nurse Employee E1 confirmed Resident R25's catheter draining bag did not have a privacy cover and that the facility failed to ensure that care was provided in a manner in which maintained Resident R25's dignity. Pa. Code: 211.10(d) Resident care policies. Pa. Code: 211.12(d)(1)(5) Nursing services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for two of five residents (Residents R35 and R79). Findings include: Review of facility policy Call Lights dated 4/17/25, indicated to assure resident has call light or alternative communication device within reach at all times when unattended. Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident R35's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/7/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and need for assistance with personal care. During an observation on 5/19/25, at 10:02 a.m. Resident R35's call bell was observing hanging from the wall unit at the head of the bed, out of the resident's reach. During an interview on 5/19/25, at 10:23 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R35's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R35's call bell needs. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), hemiplegia (paralysis on one side of the body), and muscle weakness. During an observation on 5/19/25, at 10:12 a.m. Resident R79's call bell was observed on the floor, out of the resident's reach. During an interview on 5/19/25, at 10:19 a.m. LPN Employee E1 confirmed Resident R79's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R79's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, observation, clinical record review and staff interview it was determined that the facility failed to obtain a physician order, develop a resident centered care plan, and determine resident safety for the placement of a bed against the wall for two of two residents (Resident R103, and R106). Findings include: Review of the facility policy Physical Restraint dated 4/17/25, indicated each resident is to attain and maintain his/her highest practical well-being in an environment that prohibits the use of restraints for discipline or convenience and limits use of restraints use to circumstances in which the resident has medical symptoms that warrant the use of restraint. The use of restraint will be a last resort alternative intervention. Review of Resident R103's clinical record indicated an admitted [DATE]. Review of resident 103's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/8/25, indicated the diagnosis of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), repeated falls, and difficulty walking. During an observation on 5/19/25, at 10:01 a.m. Resident R103's bed was pushed up against the wall. A review of Resident R103's clinical record failed to indicate that Resident R103 had been evaluated for safety of the bed to be up against the wall, failed to include a physician's orders for the bed to be against the wall, and failed to include a care plan for a bed to be against the wall. Review of Resident R106's clinical record indicated an admitted [DATE]. Review of resident 106's MDS dated [DATE], indicated the diagnosis of high blood pressure, difficulty swallowing, and chronic pain. During an observation, and interview on 5/19/25, at 10:08 a.m. Resident R106's bed was pushed up against the wall. Resident R106 stated that he had not asked for the bed to be placed against the wall. A review of Resident R106's clinical record failed to indicate that Resident R106 had been evaluated for safety of the bed to be up against the wall, failed to include a physician's orders for the bed to be against the wall, and failed to include a care plan for a bed to be against the wall. During an interview completed on 5/22/25, at 9:58 a.m. the Director of Nursing confirmed that the facility failed to obtain a physician order, develop a resident centered care plan, and determine resident safety for the placement of a bed against the wall for two of two residents (Resident R103 and R106). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28. Pa Code 201.14(a) Responsibility of licensee. 28 Pa. Code: 201. 18(e)(1) Management. 28 Pa. Code 211. 12(d)(5) Nursing Services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R35 and R182), and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of three resident hospital transfers (Residents R25, R35, and R182). Findings include: Review of facility policy Medical Emergency dated 6/3/24, last reviewed 4/17/25, indicated if transfer is required complete transfer form and send appropriate documentation with the resident. Review of facility policy Bed Holds dated 6/3/24, last reviewed 4/17/25, indicated upon transfer out, nursing will provide a copy of the Notice to the resident. Within 24 hours of the transfer, but no more than 48 hours, the Customer Experience Director (CED) will mail the Notice to the resident and/or Representative for signature and return. Mailing of the Notice will be noted in PCC (electronic medical record). Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of the clinical record indicated Resident R25 was transferred to the hospital on 2/18/25, and returned to the facility on [DATE]. Review of Resident R25's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/18/25. Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident R35's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and need for assistance with personal care. Review of the clinical record indicated Resident R35 was transferred to the hospital on 2/26/25, and returned to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R35's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R35's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/28/25. Review of the clinical record indicated Resident R182 was admitted to the facility on [DATE]. Review of Resident R182's MDS dated [DATE], indicated diagnoses of Coronary Artery Disease (damage or disease in the heart's major blood vessels), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and Cerebrovascular Accident (CVA - also known as a stroke, sudden interruption of blood flow to the brain). Review of the clinical record indicated Resident R182 was transferred to the hospital on 4/30/25, and remained out to the hospital at the time of review on 5/19/25. Review of Resident R182's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R182's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/30/25. During an interview on 5/22/25, at 10:39 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R35 and R182). During an interview on 5/22/25, at 11:16 a.m. CED Employee E11 confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for three of three resident hospital transfers (Residents R25, R35, and R182). 28 Pa. Code: 201.29 (a)(c)(3)(2) Resident rights.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for five of six residents (Residents R11, R22, R28, R73, and R100). Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 calendar days following admission (admitted plus 13 calendar days), and an annual MDS assessment was to be completed no later than the Assessment Reference Date (ARD) plus 14 calendar days. Resident R11 had an annual ARD of 11/6/24, and was due to be completed 11/20/24. The MDS was signed off as completed on 11/22/24, two days after the due date. Resident R22 had an admitted [DATE], with an MDS completion date of 11/26/24. The MDS was signed off as completed 12/3/24, seven days after the due date. Resident R28 had an annual ARD of 11/11/24, and was due to be completed 11/25/24. The MDS was signed off as completed 12/1/24, six days after the due date. Resident R73 had an admitted [DATE], with an MDS completion date of 10/21/24. The MDS was signed off as completed 10/22/24, one day after the due date. Resident R100 had an admitted [DATE], with an MDS completion date of 2/13/25. The MDS was signed off as completed 2/24/25, 11 days after the due date. During an interview on 5/21/25, at 12:33 p.m. Registered Nurse Assessment Coordinator Employee E8 confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for five of six residents. 28 Pa. Code 211.5(f) Medical records.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 48546 Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that that quarterly Minimum Data Set assessments were completed within the required time frame for one of six residents (Resident R73). Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that quarterly MDS assessments were to be completed no later than 14 calendar days after the Assessment Reference Date (ARD). Resident R73 had a quarterly ARD of 12/24/24, and was due to be completed 1/7/25. The MDS was signed as completed on 1/15/25, eight days after the due date. During an interview on 5/21/25, at 12:33 p.m. Registered Nurse Assessment Coordinator Employee E8 confirmed that the facility failed to make certain that quarterly Minimum Data Set assessments were completed in the required time frame for Resident R73. 28 Pa. Code 211.5(f) Medical records.

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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** 48546 Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for three of six residents (Residents R22, R38, and R79). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section N0415: High-Risk Drug Classes: Use and Indication, Question N0415E1 - Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 day). - Section O0110K1: Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions, within the last 14 days. - Section P0100: Physical Restraints: identify all physical restraints that were used at any time (day or night) during the 7-day look-back period. Code 0 if not used, code 1 if used less than daily during the observation period, and code 2 if used daily during the look-back period. Review of the clinical record indicated Resident R22 was admitted to the facility on [DATE]. Review of Resident R22's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), paraplegia (paralysis that primarily affects the lower half of the body), and muscle weakness. Question N0415E1 indicated the resident received an anticoagulant during the 7-day look-back period. Review of Resident R22's clinical record failed to include a physician order for an anticoagulant medication. During an interview on 5/21/25, at 12:33 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E8 confirmed Resident R22's MDS dated [DATE], was incorrectly coded for anticoagulant use. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of epilepsy (brain condition that causes reoccurring seizures), diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time), and major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a range of emotional and physical problems). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician order dated 3/4/25, indicated to admit Resident R38 to hospice services, effective 2/4/25. Review of Resident R38's MDS dated [DATE], revealed that Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period. During an interview on 5/21/25, at 12:24 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E9 stated that he made an entry error; made a mistake. During an interview on 5/21/25, at 12:25 p.m. RNAC Employee E8 confirmed that the facility failed to make certain that Resident R38's assessment was accurate as required. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's MDS dated [DATE], indicated diagnoses of anemia, hemiplegia (paralysis on one side of the body), and muscle weakness. Question P0100G was coded 2 used daily for restraints, chair prevents rising. Review of Resident R79's clinical record failed to include a physician order or assessment for physical restraint use. During an interview on 5/22/25, at 10:24 a.m. the Director of Nursing (DON) stated, This is a restraint-free facility and I think Resident R79 uses a regular wheelchair. During an interview on 5/22/25, at 10:27 a.m. LPNAC Employee E9 confirmed Resident R79's MDS dated [DATE], was incorrectly coded for restraint use. During an interview on 5/22/25, at 2:15 p.m., the Nursing Home Administrator (NHA) and the DON confirmed that the facility failed to ensure that MDS assessments accurately reflected the resident's status for three of six residents (Residents R22, R38, and R79). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for two of three residents (Residents R12 and R22). Findings include: Review of facility policy Comprehensive Care Plan dated 6/3/24, and last reviewed 4/17/25, indicated to allow each individual or individual's representative to make informed choices about accepting or declining care and treatment. The care plan reflects an individual's choices, either as offered by the individual directly or via a valid advance directive, or based on a decision made by the individual's representative in accordance with state law. Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/15/25, indicated diagnoses of high blood pressure, Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions), and muscle weakness. Review of Resident R12's clinical record revealed a Nursing Review - V10 assessment dated [DATE]. Review of the documentation indicated Resident R12 used any type of tobacco product or a vaping device and the resident's Plan of Care had been reviewed up and updated to reflect tobacco use. Review of Resident R12's care plan revealed a plan of care related to smoking was developed on 5/19/25. Review of Resident R12's clinical record failed to reveal documentation to indicate a plan of care related to smoking had been developed prior to 5/19/25. Review of the clinical record indicated Resident R22 was admitted to the facility on [DATE]. Review of Resident R22's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), paraplegia (paralysis that primarily affects the lower half of the body), and muscle weakness. Review of Resident R22's clinical record revealed a Nursing Review - V10 assessment dated [DATE]. Review of the documentation indicated Resident R22 used any type of tobacco product or a vaping device and the resident's Plan of Care had been reviewed up and updated to reflect tobacco use. Review of Resident R22's care plan revealed a plan of care related to smoking was developed on 5/19/25. Review of Resident R22's clinical record failed to reveal documentation to indicate a plan of care related to smoking had been developed prior to 5/19/25. During an interview on 5/22/25, at 10:39 a.m. the Director of Nursing confirmed that the facility failed to develop comprehensive care plans to meet resident care needs for Residents R12 and R22. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on clinical records and staff interview, it was determined that the facility failed to revise a care plan to accurately reflect the current status for one of six residents (Resident R65). Findings include: Review of clinical record indicated Resident R65 was admitted to the facility on [DATE], with diagnoses that included adult failure to thrive, chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs resulting in inflammation inside the airways that limit airflow into and out of the lungs) and asthma. Review of Resident R65's Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 5/5/25, indicated the diagnoses remain current. Review of Resident R65's physician orders dated 3/23/25 Regular, 7EC (Easy to Chew) diet, Allergic to milk and strawberries. Review of Resident R65's Resident Care Plan Summary Report (report nurse aides used to know what kind of care to provide) dated 2/24/25, revealed no allergy. During an interview on 5/20/25, at 2:15 p.m. Dietary Manager E16 confirmed the facility failed to revise care plan for food allergies Resident R65 as required. 28 Pa. Code: 211.11(d) Resident Care Plan

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, job descriptions, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services to meet the accepted standards of practice by failing to administer medications to the correct resident for one of five residents (Resident R182). Findings include: Review of facility policy Specific Medication Administration Procedures dated 4/17/25, indicated to review the 5 Rights of medication administration (right medication, right patient, right dose, right route, right time) three times. Identify the resident using two identification methods before administering medication (e.g., photo plus verbal confirmation of last name, photo and confirmation by family member, etc.) Review of the facility Licensed Practical Nurse (LPN) job description indicated the LPN administers medications to residents in an accurate, timely manner. Review of the clinical record indicated Resident R182 was admitted to the facility on [DATE]. Review of Resident R182's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/25, indicated diagnoses of Coronary Artery Disease (damage or disease in the heart's major blood vessels), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and Cerebrovascular Accident (CVA - also known as a stroke, sudden interruption of blood flow to the brain). Review of a progress note dated 4/30/25, completed by Certified Registered Nurse Practitioner (CRNP) Employee E18 stated, Resident was seen for hypoxia (the absence of enough oxygen in the tissues to sustain bodily functions) and vomiting. - After assessment, there was concern for respiratory depression and abdominal distress. Ordered CXR (chest x-ray) and Abdominal xray. After about an hour, it was discovered that the resident likely got another residents medications which included long acting narcotic (a controlled medication that can dull senses, relieve pain, and include sleep), beta blocker (a medication used to treat high blood pressure and heart rate), SSRI (Selective Serotonin Reuptake Inhibitor, a medication used to increase Serotonin in the brain), Anticoagulant (a medication used to prevent blood from clotting), oral diabetic med (a medication used to lower blood sugar levels), calcium channel blocker (a medication used to treat high blood pressure), and diuretic (a medication used to lower blood pressure and fluid retention). Resident sent to the hospital for evaluation. Will follow up on return. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Emergency Medicine Physical Evaluation dated 4/30/25, completed by an emergency room physician stated, Altered mental status, patient was given wrong medications this morning. He was given heart medications, blood pressure medications, narcotics/opiates, lasix (a diuretic), and blood thinners. Upon EMS (Emergency Medical Service) arrival patient was bradycardic (slow heart rate less than 60 beats per minute), hypotensive (low blood pressure), and confused. EMS gave 1 mg (milligram) of Narcan (Naloxone - a medication used to treat known or possible opioid overdose), 1 mg atropine (a medication used to treat low heart rate), and 4 mg of zofran (a medication used to treat nausea and vomiting). EMS reports that the patient was given 18 medications in error this morning that belonged to another patient. He was then found unresponsive. EMS reports that the medications the patient had given included oxycodone among others, so the patient was given naloxone with improvement in his mental status. He was initially very bradycardic with heart rates in the 30s as well and hypotensive. EMS reports that after a 500 cc (milliliters) IV (intravenous) fluid bolus the patient's heart rate improved to the 60s in a sinus rhythm and blood pressure improved to 120s over 80s. The medications that the patient received this morning included amlodipine, extended release oxycodone, cefadroxil, escitalopram, folic acid, furosemide, empagliflozin, metoprolol tartrate, omeprazole, saccharomyces, Senokot, thiamine, vitamin-C, rivaroxaban, and Carafate. EMS does report 1 episode of vomiting prior to their arrival. EMS administered Zofran EN route as well. The patient is unable to contribute significantly to history due to altered mental status. He denies pain. The patient will be admitted for further observation and management. Review of facility investigation documents dated 4/30/25 stated, LPN E2 is confident he [Resident R182] received Resident R42's medications at 7:39 a.m. CNA (Certified Nurse Aide) identified resident to be not baseline at 8:56 a.m. Blood pressure 96/52 mmHg (millimeters of mercury), heart rate 48, oxygen saturation 85% on room air, respirations 16 at 8:58 a.m. 2 liters of oxygen applied immediately. Review of facility investigation documents indicated the following medications were incorrectly administered by LPN Employee E2 to Resident R182 on 4/30/25: - Senna-Docusate (a laxative) 8.6-50 mg, two tablets - Vitamin C 500 mg - Xtampza (an opioid used to treat pain) ER (extended release) 13.5 mg - Carafate (a medication used to treat ulcers in the small intestines) 1 gm (gram) - Cefadroxil (a medication used to treat infections) 1 gm - Metoprolol Tartrate (a medication used to lower blood pressure) 50 mg - Miralax (a medication used to treat constipation) powder 17 gm - Omeprazole (a medication used to treat acid reflux) 20 mg - Thiamine (Vitamin B1) 100 mg - One-Daily Multi Vitamins tablet (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Rivaroxaban (a medication used to thin the blood and prevent clotting) 10 mg - Saccharomyces boulardii (a probiotic) 250 mg - Folic Acid 1 mg - Furosemide (a medication used to rid the body of excess water) 20 mg, give 1.5 tablet (30 mg) - Amlodipine (a medication used to lower blood pressure) 10 mg - Empagliflozin (a medication used to lower blood sugar) 10 mg - Escitalopram (a medication used to treat depression) 200 mg Review of a witness statement dated 4/30/25, completed by LPN Employee E2 stated, On Wednesday 4/30/25 I was working the medication cart on front hall of GRU. I gave Resident R182 accidentally and unknowingly another resident's medications. At approximately 7:59 a.m. a nurse aide informed me he did not look well. On my way to assess him, I saw one of the CRNPs and asked her to help me assess Resident R182 and wasn't sure yet what was wrong. Upon entering the room, he appeared tired. When I asked if he was ok he replied I need to throw up. Resident did throw up in basin. While CRNP spoke to him, I grabbed everything to assess his vitals. Pulse oxygen on room air was 85%, applied nasal cannular at 2 liters per minute and notified CRNP Employee E18. Stayed with resident to monitor for a little while. Expressed to nursing peer that I was concerned about him. CRNP Employee E18 informed me a chest x-ray was being ordered in case of the event of aspiration. When CRNP Employee E18 assessed pulse oxygenation it was 99% at 3 liters per minute and heart rate was in the upper 40s. I thought it would be ok to return to med cart briefly to get Resident R42's oxycodone after being told by staff he was asking for it. It was then when I noticed my signature of Xtampza listed on first page of narc sheet. I began to look at medication passed earlier. When I saw Resident R42's meds signed off I immediately realized I did not give them to him and they went to Resident R182. I immediately self-reported to the Registered Nurse Supervisor when I realized what took place. Supporting staff notified physician and administration. Resident was transported to the hospital via ambulance. During an interview on 5/19/25, at 12:24 p.m. LPN Employee E2 stated, I got distracted that morning, there were a lot of people talking to me. The aide came to me and said Resident R182 didn't look well, he said he felt sick, like he needed to puke. I grabbed the Nurse Practitioner (NP), who assessed the resident. The NP thought he just had an upset stomach, but he didn't look good. I think his blood pressure was 94/48, his pulse ox (oxygen saturation) was 84%, he was sweating. The ADON (Assistant Director of Nursing) stepped in, I went back to the medication cart and the wound care nurse let me know that Resident R42 across the hall wanted his oxycodone. When I went to sign out his oxycodone, I saw his Xtampza was already signed out, that's when I realized I had given Resident R42's medications to Resident R182. I was never told the best method is to bring the medication cart with me to each resident room. During orientation, I was trained by two different LPNs, neither of them told me to use the pictures in the electronic medical record to verify residents. They must have thought that was common sense. That experience was so scary, I could have killed that person. During an interview on 5/20/25, at 1:57 p.m. the Director of Nursing confirmed that the facility failed to provide care and services to meet the accepted standards of practice by failing to administer medications to the correct resident for one of five residents (Resident R182). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a resident's interview, clinical record review and review of the facility policy, it was determined that the facility failed to provide supervision with meals as ordered for one of three residents (Resident R23). Finding include: Review of the facility policy titled, Physician Orders last reviewed 4/17/25, stated physician orders are followed in accordance with good nursing principles and practices. Review of Resident R23's admission record indicated she was admitted to the facility on [DATE], with diagnoses of cerebral infarction (occurs when blood flow to the brain is cut off) and dysphagia (difficulty swallowing), and abnormal posture. Review of Resident R23's physician order dated 8/23/25, revealed the resident requires direct supervision with meals for assistance with feeding. The resident enjoys eating in the dining room. Review of Resident R23's care plan dated 7/29/24, revised 5/15/25, indicated the resident needs assisted with meals but is resistive to others helping him eat. Review of Resident R23's MDS assessment dated [DATE], indicated the diagnoses were current. During an observation on 5/19/25, at 12:28 p.m. Resident R23 was observed sitting in his room, lying in bed with his lunch tray in front of him. Resident R23 was left unattended, and was not supervised for his meal as ordered. During an interview on 5/19/25, at 12:31 p.m. Licensed Practical Nurse, Employee E2 confirmed Resident R23 was not supervised with his meal as ordered. During an interview on 5/20/25, at 12:56 p.m. the Director of Nursing confirmed the facility failed to provide supervision with meals as ordered for one of three residents (Resident R23). 28 Pa. Code 211.109d) Resident care policies 28 Pa. Code 211.12(c)(d)(1) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for three of nine residents (Residents R25, R105, and R186). Findings include: Review of facility policy Physician Orders dated 6/3/24, and last reviewed 4/17/25, indicated physician orders are followed in accordance with good nursing principles and practices. The purpose is to ensure that the residents receive all medications and treatments that are ordered by the physician in a timely manner. Review of facility policy Bowel Management dated 4/17/25, indicated the standard regimen for bowel management will be followed for a resident who experiences alteration in bowel elimination. The purpose is to provide regularity of bowel movement and prevent constipation. On the 3rd day without a bowel movement, two tablets of Senna must be administered by mouth. On the 4th day, if Senna is ineffective, give Bisacodyl suppository rectally. On the evening of the 4th day, if Bisacodyl suppository is ineffective, administer a fleet enema rectally. If still no bowel movement after completion of protocol, notify physician. Document administration of medication in electronic record and effectiveness in nurses notes. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's (capillary blood glucose). Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL (milligrams per deciliter) while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of high blood pressure, diabetes, and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 3/7/25, indicated to administer Humalog insulin, inject per sliding sale subcutaneously (beneath the skin into the fatty tissue layer) before meals: - 0 - 130 = 0 units - 131 - 180 = 2 units - 181 - 240 = 4 units - 241 - 300 = 6 units - 301 - 350 = 8 units - 351 - 400 = 10 units - 401 - 999 = 12 units, notify MD (physician) Review of Resident R25's April and May 2025 vitals records indicated the following blood glucose measurements: - 4/19/25 at 3:42 p.m. = 454 mg/dL - 4/29/25 at 4:32 p.m. = 404 mg/dL - 5/10/25 at 4:38 p.m. = 492 mg/dL - 5/12/25 at 4:39 p.m. = 522 mg/dL Review of Resident R25's progress notes from 4/19/25, through 5/22/24, failed to include documentation that the physician was notified of the resident's increased blood glucose levels on the dates listed above. During an interview on 5/22/25, at 12:51 p.m. the Director of Nursing confirmed that the facility failed to document that the physician was notified of Resident R25's increased blood glucose levels and that the facility failed to make certain that Resident R25 was provided appropriate treatment and care. Review of the clinical record indicated Resident R105 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of high blood pressure, phantom limb pain syndrome with pain, and constipation. Review of Resident R105's care plan dated 8/25/23, indicated the resident had mixed bladder incontinence. Interventions included to monitor the resident for possible medical causes for incontinence such as bladder infection and constipation. The facility failed to ensure Resident R105 had an individualized care plan with interventions to address constipation. Review of Resident R105's physician order dated 4/23/24, indicated to administer two tablets of 8.6 mg Senna, every 24 hours as needed for constipation on the 3rd day without a bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R105's physician order dated 4/23/24, indicated to administer one 10 mg Bisacodyl suppository rectally every 24 hours as needed for constipation on the 4th day, if Senna ineffective, give Bisacodyl suppository rectally. Review of Resident R105's physician order dated 4/23/24, indicated to administer one 7-19 gram/118 milliliter Fleet Enema, every 24 hours as needed for constipation on the evening of the 4th day, if Bisacodyl suppository ineffective, give Fleet enema rectally. If still no bowel movement, notify clinician. Review of Resident R105's physician order dated 7/2/24, indicated to administer two tablets of 8.6-50 mg Sennosides-Docusate Sodium for constipation. Review of Resident R105's physician order dated 12/4/24, indicated to administer one tablet of 7.5 mg Meloxicam at bedtime for pain management. Review of Resident R105's MDS dated [DATE], indicated diagnoses were current. Review of Resident R105's clinical record revealed the following: -2/10/25, Resident R105 failed to have a bowel movement. -2/11/25, Resident R105 had a small loose bowel movement. -2/12/25, to 2/18/25, Resident R105 failed to have a bowel movement. A total of 6 days. Review of Resident R105's February 2025 Medication Administration Record failed to reveal the resident received medications as ordered per the bowel protocol. Review of Resident R105's progress note dated 2/17/25, at 11:40 a.m. entered by Medical Doctor, Employee E19 indicated the resident tends to run more on the constipated side. Review of Resident R105's progress note dated 2/17/25, at 12:07 p.m. entered by Registered Nurse, Employee E20 indicated the resident was assessed due to no bowel movements in six days. Bowel sounds were hyperactive in all four quadrants. Resident R105 stated she hasn't been eating as much. Review of a physician order dated 2/18/25, indicated to obtain an abdominal x-ray due to constipation to rule out ileus. Review of Resident R105's progress note dated 2/19/25, revealed the x-ray was reviewed and there was significant stool in the colon. During an interview on 5/21/25, at 1:48 p.m. Certified Registered Nurse Practitioner, Employee E18 stated the bowel protocol should be started on day three of no bowel movement. Certain medications are administered based on the bowel protocol. It was indicated in morning meetings staff review the residents who have not had a bowel movement in 3, 4, 5, or 6, days. If a resident refuses medications the provider must be notified. CRNP, Employee E18 stated Resident R105 is on scheduled narcotics for phantom pain and she is not really one to refuse medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25, at 2:03 p.m. Licensed Practical Nurse, Employee E21 stated to prevent residents from becoming constipated, the facility utilizes a bowel protocol and monitor the resident's bowel pattern daily through the nurse aide documentation. If a resident fails to have a bowel movement after three days, then the bowel protocol is implemented. A small bowel movement does not count as an actual bowel movement. LPN, Employee E21 stated the clinical record will trigger an alert after a resident fails to have a bowel movement in three days. The Registered Nurse must address the alert. During an interview on 5/21/25, at 2:15 p.m. RN, Employee E10 stated only an RN may clear the alert that a resident has not had a bowel movement. RN, Employee E10 stated she confirms the resident did not have a bowel movement with documentation. Once it is confirmed, the bowel protocol is implemented. On day 3, senna is administered, then a suppository on Day 4, and a fleet enema on day 5. If a resident refuses, the medications, staff should encourage the resident and keep offering. Each time the resident refuses the medication, it must be documented. On day 6, the physician must be notified to see if an x-ray needs to be ordered. During an interview on 5/21/25, at 2:20 p.m. the Director of Nursing confirmed that the facility failed to timely implement the bowel protocol for one of six residents (Resident R105). Review of Resident R186's admission record indicated he was admitted on [DATE]. Review of Resident R186's MDS assessment dated [DATE], indicated he had diagnoses that included paraplegia (a form of paralysis impacting the lower extremities of the body), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and pressure ulcer to the right hip. Review of Resident R186's care plan dated 5/4/25, indicated to monitor the dressing to ensure it is intact and adhering. Review of Resident R186's physician orders dated 5/13/25, indicated to change wound vac three times weekly every evening shift (Tuesday, Thursday and Saturday). Set wound vac to 120 mm/Hg for every shift. Review of Resident R186's physician orders did not include a wet-to-dry dressing order and procedures in the event that the wound vac is inoperable. During an interview on 5/19/25, at 12:56 p.m. Resident R186 stated he has a wound vac and its working fine. Resident R186 observed in bed with wound vac on and operational. Settings on as per physician order. During observations on 5/21/25, at 11:21 a.m. Resident R186 observed in bed with wound vac on and operational. Settings on as per physician order. During an interview on 5/21/25, at 11:49 a.m. Licensed Practical Nurse (LPN) Employee E4 was asked about wound vac dressing should it be inoperable: He has prn if uncontrollable leaking. we do not have a wet to dry order if inoperable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25, at 2:46 p.m. information disseminated to Nursing Home Administrator (NHA) and Director of Nursing (DON) that the facility failed to make certain that Resident R186 was provided appropriate treatment orders for a wound vac. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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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** 46167 Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for one of two residents (Residents R116). Findings include: Review of facility policy Restorative Nursing Standard dated 4/17/25, indicated that the facility provides a Restorative Nursing program with interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The Restorative Nursing Coordinator facilitates communication between the interdisciplinary team and manages the Restorative Nursing program. Categories of Restorative Nursing programs include splint or brace assistance. A physician's order is obtained and entered into electronic health record. Document the restorative program in the care plan. Review of the clinical record indicated Resident R116 was admitted to the facility on [DATE]. Review of Resident R116s MDS dated [DATE], indicated diagnoses of difficulty swallowing, anoxic brain injury (lack of oxygen to the brain resulting in death of brain cells) and muscle weakness. During an observation on 5/19/25, at 12:19 p.m. Resident R116 was observed with palm guards (a brace used to prevent finger contractures and skin break down in the palm) on both hands. Review of Resident R116's clinical record failed to reveal a physician's order or a care plan for the use and management of the palm guards. Interview on 5/22/25, at 10:32 a.m. with Registered Nurse Assessment Coordinator (RNAC) Employee E3 confirmed that the facility failed to obtain a physician's order for palm guards, and failed to include care and management of the palm guards in the care plan for Resident R116. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of two residents (R79). Findings include: Review of facility policy Basic Guidelines for Enteral Feeding dated 4/17/25, indicated basic guidelines for enteral feeding will be followed by all staff delivering care to enterally fed individuals. Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE]. Review of Resident R79's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/25/25, indicated diagnoses of anemia (too little iron in the blood), hemiplegia (paralysis on one side of the body), and muscle weakness. Review of a physician order dated 4/21/25, indicated two times a day for nutrition Jevity 1.5 (a tube feeding formula) via gastric tube 80 milliliters/hour x 12 hours, up at 6 p.m. down at 6 a.m. During an observation on 5/19/25, at 10:10 a.m. Resident R79's enteral feeding bottle was observed to be dated 2/1/26. The water bag used for flushes failed to have a current date. During an interview on 5/19/25, at 10:19 a.m. Licensed Practical Nurse (LPN) Employee stated, 2/1/26 is the date that the tube feeding bottle expires, I don't know why the nurse didn't put the date the bottle was opened. During an interview on 5/19/25, at 10:19 a.m. LPN Employee E1 confirmed the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of two residents (R79). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for one of four residents (Resident R25). Findings include: Review of facility policy Oxygen Therapy via Nasal Cannula dated 4/17/25, indicated to replace cannula every seven days, date and store in plastic bag when not in use. Review of facility policy Small Volume Nebulizer dated 4/17/25, indicated to ensure equipment is dry, not damp, and place in storage bag labeled with resident's name and date equipment was used. Replace equipment every seven days. Date connecting tubing. Replace every seven days. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of a physician order dated 3/6/25, indicated to change nebulizer cup and tubing every week every night shift every Sunday. Review of a physician order dated 3/6/25, indicated to change hand-held nebulizer (a machine used to deliver aerosolized medications) and tubing weekly every night shift every Sunday. Review of a physician order dated 3/6/25, indicated to change nasal cannula (a lightweight tube use to deliver oxygen directly into the nostrils) and protective covers weekly every night shift every Sunday. Review of a physician order dated 3/6/25, indicated to administer Albuterol Sulfate Inhalation Nebulization Solution (2.5 milligrams/milliliter) 0.083%, 1 inhalation inhale orally via nebulizer every 4 hours as needed for shortness of breath, wheezing. During an observation on 5/19/25, at 10:08 a.m. Resident R25 was observed receiving oxygen at 3 liters per minute via nasal cannula. No date was observed on the nasal cannula tubing or the humidification bottle attached to the oxygen concentrator. Resident R25's nebulizer machine was observed on the bedside table with the mouthpiece on the bedside table, not stored in a bag while not in use. The connecting tubing was dated 4/22. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25, at 10:17 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R25's nasal cannula tubing and humidification bottle were not dated, the nebulizer tubing was dated 4/22, and the mouthpiece was not stored in a bag while not in use. During this interview, LPN Employee E1 confirmed that the facility failed to provide appropriate respiratory care for Resident R25. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility document, resident record review, and staff interviews, it was determined that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for four of four residents (Resident R12, R57, R58, and R116). Findings include: Review of facility job description Social Worker, indicated that the Social Worker will carry out social evaluations and plan interventions based on evaluation findings, and counsel residents/ family/caregivers as needed in relationship to stress and other identified coping difficulties. Ensure compliance with all Federal, State, and local regulations. Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/15/25, indicated diagnoses of high blood pressure, Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions), and muscle weakness. Review of Resident R12's care plan on 5/19/25, failed to addressing PTSD by identifying any triggers or how to avoid them. Review of the clinical record indicated Resident R57 was admitted to the facility on [DATE]. Review of Resident R57's MDS dated [DATE], indicated diagnoses of PTSD, high blood pressure, and chronic pain. Review of Resident R57's care plan on 5/19/25, failed to address PTSD by identifying any triggers or how to avoid them. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE], with diagnoses of post-traumatic stress disorder (PTSD), depression, and anxiety. Review of Resident R58's care plan dated 9/3/24, revealed the resident has a history of PTSD. Interventions included to Ask me about the trauma that I experienced and do not accuse me of attention seeking, but collaborate with me on my treatment plan, Have the social worker see me as needed, and If I display anxiety, ask how you can help. The facility failed to identify Resident R58's triggers and implement an individualized care plan to address Resident R58's PTSD. Review of Resident R58's Social Service assessment dated [DATE], asked if the resident has a history of PTSD and was answered no. Review of Resident R58's MDS dated [DATE], indicated diagnoses were current. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R58's clinical record on 5/21/25, at 10:10 a.m. revealed a psychiatric evaluation was completed on 12/5/23, in the hospital. The resident reported two recent inpatient psychiatric admissions following suicidal gestures. He reported he didn ' t see any purpose in living and both times put a loaded gun to his head. Resident R58 served in the military. During an interview on 5/21/25, at 11:38 a.m. Director of Social Service, Employee E7 stated in order to identify if a resident has PTSD, she looks through hospital records and completes an assessment upon admission. If the resident does have a history of trauma, then triggers are identified. The resident's care plan should identify the resident's triggers. The Director of Social Service, Employee E7 confirmed Resident R58 failed to have individualized care plan to address Resident R58's PTSD. Review of the clinical record indicated Resident R116 was admitted to the facility on [DATE]. Review of Resident R116s MDS dated [DATE], indicated diagnoses of PTSD, anoxic brain injury (lack of oxygen to the brain resulting in death of brain cells) and muscle weakness. Review of Resident R116's care plan on 5/19/25, failed to address PTSD by identifying any triggers or how to avoid them. During an interview on 5/22/25, at 9:50 p.m. Director of Social Services Employee E7 confirmed that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for four of four residents (Resident R12, R57, R58, and R116). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review, facility policy and interviews with staff, it was determined that the facility failed to ensure the physician reviewed the resident's total program of care for one of five residents (Resident R105). Findings include: Review of the facility policy Administering Medications last reviewed 12/9/24, revealed medications are administered vin a safe and timely manner, and as prescribe. If dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associate with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. Review of the clinical record indicated Resident R105 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of high blood pressure, phantom limb pain syndrome with pain, and constipation. Review of Resident R105's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated diagnoses were current. Review of Resident R105's clinical record revealed the following: -2/10/25, Resident R105 failed to have a bowel movement. -2/11/25, Resident R105 had a small loose bowel movement. -2/12/25, to 2/18/25, Resident R105 failed to have a bowel movement. A total of 6 days. Review of Resident R105's February 2025 Medication Administration Record failed to reveal the resident received medications as ordered per the bowel protocol. Review of Resident R105's progress note dated 2/17/25, at 11:40 a.m. entered by Medical Doctor, Employee E19 indicated the was seen for a monthly visit after a bilateral above the knee amputation. Medical Doctor, Employee E19 stated Resident R105 had no changes in bowel habits and tends to run more on the constipated side. Her appetite Is fair. Review of Resident R105's progress note dated 2/17/25, at 12:07 p.m. entered by Registered Nurse, Employee E20 indicated the resident was assessed due to no bowel movements in six days. Bowel sounds were hyperactive in all four quadrants. Resident R105 stated she hasn't been eating as much. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25, at 1:48 p.m. Certified Registered Nurse Practitioner, Employee E18 stated when assessing a resident during a physician visit the resident's clinical record including bowel and eating patterns are reviewed. CRNP, Employee E18 stated I feel like it's my job to check that. During an interview on 5/21/25, at 2:20 p.m. the Director of Nursing confirmed the facility failed to ensure the physician reviewed the resident's total program of care for one of five residents (Resident R105). 28 Pa. Code:211.12(d)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 41984 Based on review of personnel records, and staff interview it was determined that the facility failed to complete annual performance evaluations for three out of five nurse aides (NA Employee E13, E14 and E15). Findings include: Review of personnel files reviewed that Nurse Aide Employee E15 start date was 5/28/97, last performance evaluation was completed 10/22-10/23. Review of personnel files revealed that Nurse Aide Employee E13 last hire date was 8/17/20, last performance evaluation was completed 10/22-10/23. Review of personnel files revealed that Nurse Aide Employee E14 last hire date was 7/19/21, last performance evaluation was completed 10/22-10/23. During an interview on 5/21/24, at 12:45 p.m. Human Resources Employee E12 confirmed that the facility does not have up to date performance appraisals completed on NA Employee E13, E14 and E15. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development. 28 Pa Code: 201.14 (a) Responsibility of licensee.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician for two of two residents (Resident R19 and R182), resulting in significant medication errors due to receiving another resident's medications for one of five residents reviewed (Resident R182). This created actual harm which required a transfer to the emergency department and admission to a telemetry unit (a unit of a hospital where patients receive continuous heart monitoring) for Resident R182. Findings include: Review of facility policy Specific Medication Administration Procedures dated 4/17/25, indicated to review the five Rights of medication administration (right medication, right patient, right dose, right route, right time) three times. Identify the resident using two identification methods before administering medication (e.g., photo plus verbal confirmation of last name, photo and confirmation by family member, etc.) Review of the facility policy titled, Physician Orders last reviewed 4/17/25, stated physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. Review of the clinical record indicated Resident R19 was admitted to the facility on [DATE], with diagnoses of osteoporosis (a condition in which bones become weak and brittle), hip fracture, and arthritis (swelling and tenderness in one or more joints). Review of Resident R19's hospital discharge summary dated 4/21/25, indicated to administer 70 milligrams (mg) of Fosamax once every seven days for osteoporosis. Review of Resident R19's physician order dated 4/21/25, entered by Registered Nurse, Employee E22 indicated to administer 70 mg of Fosamax one time a day for seven days. Review of information submitted to the Department of Health on 4/28/25, stated on 4/28/25, at approximately 8:00 a.m. a Registered Nurse was alerted a medication error had occurred. Resident R19 was ordered Fosamax 70 mg every seven days and the order was entered once a day for seven days. The administration record revealed the resident received five doses of Fosamax over a seven-day period. The provider was notified and assessed the resident. The resident's family was notified and requested the resident to be sent to the hospital for further evaluation. It was indicated education will be provided to all nurses on entering orders. Review of Resident R19's April 2025 Medication Administration Record (MAR) on 5/19/25, at 9:22 a.m. revealed Resident R19 received 70 mg Fosamax on 4/22/25, 4/23/25, 4/24/25, 4/26/25, and 4/27/25. Review of the facility's investigation on 5/19/25, revealed on 4/28/25, a Nursing In Service was provided to staff of how to enter daily versus weekly orders in the electronic record. Review of the list of staff members educated failed to include evidence RN, Employee E22 was reeducated. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of RN, Employee E22's timesheet revealed she worked on 4/28/25, from 2:07 p.m. until 10:37 p.m. and 4/30/25, from 11:00 p.m. until 7:32 a.m. During an interview on 5/20/25, at 1:05 p.m. the Director of Nursing (DON) confirmed the facility failed to reeducate RN, Employee E22 and failed to ensure Resident R19 was free from significant medication errors. Review of the clinical record indicated Resident R182 was admitted to the facility on [DATE]. Review of Resident R182's MDS dated [DATE], indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and Cerebrovascular Accident (CVA - also known as a stroke, sudden interruption of blood flow to the brain). Review of a progress note dated 4/30/25, completed by Certified Registered Nurse Practitioner (CRNP) Employee E18 stated, Resident was seen for hypoxia (the absence of enough oxygen in the tissues to sustain bodily functions) and vomiting. - After assessment, there was concern for respiratory depression and abdominal distress. Ordered CXR (chest x-ray) and Abdominal x-ray. After about an hour, it was discovered that the resident likely got another residents medications which included long acting narcotic (a controlled medication that can dull senses, relieve pain, and include sleep), beta blocker (a medication used to treat high blood pressure and heart rate), SSRI (Selective Serotonin Reuptake Inhibitor, a medication used to increase Serotonin in the brain), Anticoagulant (a medication used to prevent blood from clotting), oral diabetic med (a medication used to lower blood sugar levels), calcium channel blocker (a medication used to treat high blood pressure), and diuretic (a medication used to lower blood pressure and fluid retention). Resident sent to the hospital for evaluation. Will follow up on return. Review of an Emergency Medicine Physical Evaluation dated 4/30/25, completed by an emergency room physician stated, Altered mental status, patient was given wrong medications this morning. He was given heart medications, blood pressure medications, narcotics/opiates, Lasix (a diuretic), and blood thinners. Upon EMS (Emergency Medical Service) arrival patient was bradycardic (slow heart rate less than 60 beats per minute), hypotensive (low blood pressure), and confused. EMS gave 1 mg (milligram) of Narcan (Naloxone - a medication used to treat known or possible opioid overdose), 1 mg atropine (a medication used to treat low heart rate), and 4 mg of Zofran (a medication used to treat nausea and vomiting). EMS reports that the patient was given 18 medications in error this morning that belonged to another patient. He was then found unresponsive. EMS reports that the medications the patient had given included oxycodone among others, so the patient was given naloxone with improvement in his mental status. He was initially very bradycardic with heart rates in the 30's as well and hypotensive. EMS reports that after a 500 cc (milliliters) IV (intravenous) fluid bolus the patient's heart rate improved to the 60's in a sinus rhythm and blood pressure improved to 120s over 80's. The medications that the patient received this morning included amlodipine, extended-release oxycodone, cefadroxil, escitalopram, folic acid, furosemide, empagliflozin, metoprolol tartrate, omeprazole, saccharomyces, Senokot, thiamine, vitamin-C, rivaroxaban, and Carafate. EMS does report 1 episode of vomiting prior to their arrival. EMS administered Zofran EN route as well. The patient is unable to contribute significantly to history due to altered mental status. He denies pain. The patient will be admitted for further observation and management. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of facility investigation documents dated 4/30/25 stated, Licensed Practical Nurse (LPN) E2 is confident he [Resident R182] received Resident R42's medications at 7:39 a.m. CNA (Certified Nurse Aide) identified resident to be not baseline at 8:56 a.m. Blood pressure 96/52 mmHg (millimeters of mercury), heart rate 48, oxygen saturation 85% on room air, respirations 16 at 8:58 a.m. 2 liters of oxygen applied immediately. Review of facility investigation documents indicated the following medications were incorrectly administered by LPN Employee E2 to Resident R182 on 4/30/25: - Senna-Docusate (a laxative) 8.6-50 mg, two tablets - Vitamin C 500 mg - Xtampza (an opioid used to treat pain) ER (extended release) 13.5 mg - Carafate (a medication used to treat ulcers in the small intestines) 1 gm (gram) - Cefadroxil (a medication used to treat infections) 1 gm - Metoprolol Tartrate (a medication used to lower blood pressure) 50 mg - MiraLAX (a medication used to treat constipation) powder 17 gm - Omeprazole (a medication used to treat acid reflux) 20 mg - Thiamine (Vitamin B1) 100 mg - One-Daily Multi Vitamins tablet - Rivaroxaban (a medication used to thin the blood and prevent clotting) 10 mg - Saccharomyces boulardii (a probiotic) 250 mg - Folic Acid 1 mg - Furosemide (a medication used to rid the body of excess water) 20 mg, give 1.5 tablet (30 mg) - Amlodipine (a medication used to lower blood pressure) 10 mg - Empagliflozin (a medication used to lower blood sugar) 10 mg - Escitalopram (a medication used to treat depression) 200 mg (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement dated 4/30/25, completed by LPN Employee E2 stated, On Wednesday 4/30/25 I was working the medication cart on front hall of GRU. I gave Resident R182 accidentally and unknowingly another resident's medications. At approximately 7:59 a.m. a nurse aide informed me he did not look well. On my way to assess him, I saw one of the CRNPs and asked her to help me assess Resident R182 and wasn't sure yet what was wrong. Upon entering the room, he appeared tired. When I asked if he was ok he replied I need to throw up. Resident did throw up in basin. While CRNP spoke to him, I grabbed everything to assess his vitals. Pulse oxygen on room air was 85%, applied nasal cannula at 2 liters per minute and notified CRNP Employee E18. Stayed with resident to monitor for a little while. Expressed to nursing peer that I was concerned about him. CRNP Employee E18 informed me a chest x-ray was being ordered in case of the event of aspiration. When CRNP Employee E18 assessed pulse oxygenation it was 99% at 3 liters per minute and heart rate was in the upper 40's. I thought it would be ok to return to med cart briefly to get Resident R42's oxycodone after being told by staff he was asking for it. It was then when I noticed my signature of Xtampza listed on first page of narc sheet. I began to look at medication passed earlier. When I saw Resident R42's meds signed off I immediately realized I did not give them to him, and they went to Resident R182. I immediately self-reported to the Registered Nurse Supervisor when I realized what took place. Supporting staff notified physician and administration. Resident was transported to the hospital via ambulance. During an interview on 5/19/25, at 12:24 p.m. LPN Employee E2 stated, I got distracted that morning, there were a lot of people talking to me. The aide came to me and said Resident R182 didn't look well, he said he felt sick, like he needed to puke. I grabbed the Nurse Practitioner (NP), who assessed the resident. The NP thought he just had an upset stomach, but he didn't look good. I think his blood pressure was 94/48, his pulse ox (oxygen saturation) was 84%, he was sweating. The ADON (Assistant Director of Nursing) stepped in, I went back to the medication cart and the wound care nurse let me know that Resident R42 across the hall wanted his oxycodone. When I went to sign out his oxycodone, I saw his Xtampza was already signed out, that's when I realized I had given Resident R42's medications to Resident R182. I was never told the best method is to bring the medication cart with me to each resident room. During orientation, I was trained by two different LPNs, neither of them told me to use the pictures in the electronic medical record to verify residents. They must have thought that was common sense. That experience was so scary, I could have killed that person. During an interview on 5/20/25, at 1:57 p.m. the DON confirmed that the facility failed to provide medication as ordered by the physician, resulting in significant medication errors due to Resident R182 receiving another resident's medications. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in two of two medications rooms (Angel Wing Medication Room and GRU Medication Room), and two of three medication carts (Angel Wing Back Medication Cart and GRU Back Hall Medication Cart). Findings include: Review of facility policy Storage of Medications dated [DATE], indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 C (36 F) and 8 C (46 F) with a thermometer to allow temperature monitoring. The facility shoulder maintain a temperature log in the storage area to record temperatures at least once a day. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. During an observation on [DATE], at 9:28 a.m. of the Angel Wing Back Hall Medication Cart indicated the following medications not dated upon opening: - Resident R27's Breo Ellipta inhaler (a medication used to treat asthma and COPD) - Resident R29's Umelidinium-Vilantero inhaler (a medication used to improve breathing and reduce flare-ups of COPD symptoms) - Resident R61's Breo Ellipta inhaler - Resident R386's Breo Ellipta inhaler During an interview on [DATE], at 9:33 a.m. Licensed Practical Nurse (LPN) Employee E5 confirmed the above observations and that the facility failed to properly store medications on the Angel Wing Back Hall Medication Cart. During an observation on [DATE], at 9:36 a.m. of the Angel Wing Medication Room Refrigerator Temperature Log revealed the following dates with no recorded temperatures: [DATE], [DATE], [DATE], and [DATE]. During an observation on [DATE], at 9:41 a.m. revealed the following expired supplies in the Angel Wing medication Room: - Non-conductive connecting tubing, expired [DATE] - 20 gauge IV (intravenous) catheter, expired [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 24 gauge IV catheter, expired [DATE] - 24 gauge IV catheter, expired [DATE] - 1 milliliter 27 gauge needle safety syringe, expired [DATE] During an interview on [DATE], at 9:46 a.m. LPN Employee E6 confirmed the above observations and that the facility failed to properly store medications in the Angel Wing Medication Room. During an observation on [DATE], at 11:35 a.m. of the GRU Medication Room refrigerator, a COVID vaccine was observed in the refrigerator with an expiration date of [DATE]. During an interview on [DATE], at 11:35 a.m. LPN Employee E21 confirmed the above observation and that the facility failed to properly store medications in the GRU Medication Room. During an observation of the GRU back hall medication cart on [DATE], at 11:02 a.m. the following was observed: -Resident R5's Toujeo 30 units/milliliter (ml) Insulin pen was not stored in a bag -Resident R7's Fluticasone Propionate 250mcg/50mcg inhaler was not stored in a bag During an interview on [DATE], at 11:08 a.m. Licensed Practical Nurse, Employee E21 confirmed the above findings. 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46167 Based on a review of four-week cycle menu, and staff interviews, it was determined that the facility failed to have a registered dietitian review and approve the menu and nutritional substitutes prior to implementation for one out three meals served on 4/25/25 (lunch). Findings include: During an interview on 5/19/25, at 2:18 p.m. Dietary Manager (DM) Employee E16 stated that the facility prepared a special meal on 4/25/25, that was designed to enter a competition amongst sister facilities for a cook-off. DM Employee E16 stated that she then adapted this recipe for Braised Beef Tips to be served to the residents for lunch on 4/25/25. Review of the four-week menu cycle failed to indicate that the lunch meal for 4/25/25, included a signature of approval from a registered dietitian. During an interview on 5/21/25, at 1:20 p.m. Registered Dietitian Employee E17 confirmed that the facility failed to acquired approval for the special menu served on lunch 4/25/25, from a Registered Dietitian prior to serving. 28 Pa Code: 211.6(a) Dietary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45577 Based on a review of facility policy, observation and staff interview, it was determined that the facility failed to monitor and maintain records of refrigeration/freezer temperature logs to make certain refrigeration/freezers function properly and failed to properly maintain cleanliness and sanitation of the Kitchen areas (Main Kitchen). Findings include: Review of facility policy Food Safety and Sanitation, dated 4/17/25, indicated that all local, state and federal standards and regulations are followed in order to assure a safe and sanitary food services department. Review of facility policy Cleaning Instructions: Refrigerators, dated 4/17/25, indicated the refrigerators will be washed thoroughly inside and outside with a detergent and followed by a sanitizer at least once weekly, or as needed. Spills and leaks will be cleaned as they are noticed. During an interview on 5/19/25, at 10:00 a.m., Dietary Manager (DM) Employee E16 revealed that the facility kitchen has been under construction since December 2024, and that tasks as spilt between the Skilled Nursing (SNF) Dining room and the Personal Care (PC) kitchen. DM Employee E16 further revealed that the facility has a portable freezer located outside PC kitchen to support need for frozen storage. During an observation of the portable freezer on 5/19/25, at 10:20 a.m. revealed that facility failed to monitor and document twice daily freezer temperatures for proper temperature maintenance. Interview with DM Employee E16 at time of observation confirmed facility failed to properly monitor freezer temperatures as required. During an observation of the walk-in cooler in the PC kitchen on 5/19/25, at 10:25 a.m. revealed the following: - the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris. - the floor had a build-up of grime, spilled/dried food debris below shelving racks. During an observation of the Cook's Prep reach-in cooler in the SNF Dining Room area on 5/19/25, at 10:41 a.m., revealed a build-up of black, fuzzy debris on the top coated wire shelving of the cooler. During an interview on 5/19/25, at 10:45 a.m., DM Employee E16 confirmed that the facility failed to properly maintain cleanliness and sanitation of the Kitchen areas, and failed to monitor and maintain records of refrigeration/freezer temperature logs to make certain refrigeration/freezers function properly. 28 Pa. Code: 201.14(a) Responsibility of licensee. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code: 201.18(b)(1) Management.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R38). Findings include: Review of facility policy Hospice Referral dated 4/17/25, indicated that a hospice referral will be initiated in accordance with resident and family wishes. Care will be coordinated with the resident's physician, pharmacy, and responsible party as appropriate. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS (MDS-Minimum Data Set assessment: periodic assessment of resident care needs)dated 3/24/25, indicated diagnoses of epilepsy (brain condition that causes reoccurring seizures), diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time), and major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a range of emotional and physical problems). Section O-0110 Special treatments indicated an x for hospice services. Review of physician order dated 3/4/25, indicated to admit Resident R38 to hospice services, effective 2/4/25. Review of Resident R38's hospice records revealed a form Hospice/LTC Coordinated Task Plan of Care, dated 2/4/25, which indicated that two times per week that a Hospice Registered Nurse (RN) and a Hospice Nurse Aide (NA) would visit resident as part of contracted service provided. Review of Resident R38's clinical record and hospice record failed to reveal consistent hospice RN or NA visit documentation two times per week as indicated from 2/4/25, through 5/22/25. During an interview on 5/22/25, at 1:42 p.m., the Director of Nursing (DON) confirmed the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R38). 28 Pa Code: 211.12 (d)(3)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, resident clinical records, facility documents, and staff interviews, it was determined that the facility failed to timely enter an order for isolation for one of nine residents (Resident R68) and have a surveillance plan for tracking, and monitoring residents who tested negative for Influenza during an outbreak for two of ten months (February 2025 to March 2025). Finding include: Review of the Respiratory Virus Outbreak Toolkit dated 11/14/24, indicated a case-line listing is designed to collect information about all ill cases (residents and staff) during an outbreak in a long-term care facility. It was indicated upon identification of an outbreak, use this template to collect and organize information on cases. The type of test ordered and if pathogens were detected must be recorded. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of influenza, anxiety, and depression. Review of Resident R68's progress note dated 2/20.25, revealed the resident was mumbling her words, started running a fever around 2 p.m. The Tylenol was non-effective. Oxygen was 77% on room air. Resident was transferred to hospital. Review of the facility's line listing revealed Resident R68 was positive for flu on 2/20/25. Review of Resident R68's progress note dated 2/23/25, indicated the resident returned from the hospital. Review of Resident R68's physician orders failed to include an order for isolation on 2/23/25 and 2/24/25. The facility failed to ensure an order for droplet precautions was entered timely. Review of the facility's line listing for respiratory illnesses on 5/22/25, at 9:45 a.m. revealed the most recent flu outbreak started on 2/20/25, and the last positive was on 3/10/25. One resident tested positive for COVID on 2/27/25. A further review failed to include residents who tested negative. During an interview on 5/22/25, at 9:58 a.m. the Director of Nursing stated I am unsure why negative results would not be tracked. The DON stated I will check to see if there is an internal document that reveals everyone that was tested . During an interview on 5/22/25, at 9:58 a.m. the Director of Nursing confirmed the line listing is where IP, Employee E23 tracks residents who tested negative. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25, at 10:29 a.m. IP, Employee E23 confirmed the facility failed to timely enter an order for isolation for one of nine residents (Resident R68) and have a surveillance plan for tracking, and monitoring residents who tested negative for Influenza during an outbreak for two of ten months (February 2025 to March 2025). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12 (d)(1)(2)(3) Nursing Services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for three of three crash carts (GRU, Angel Wing, and Buttercup) and one of one AEDs (Automatic External Defibrillators). Findings include: Review of facility policy Emergency Cart dated [DATE], indicated an emergency cart will be appropriately stocked and ready for use when attempting to resuscitate ad resident. The cart will be readily available for use and its inventory maintained. The cart will have a numbered break-away lock on it at all times. The cart is stocked according to the Crash Cart Inventory List and the unbroken numbered lock indicates that all items are present and accounted for. The numbered lock will be checked and recorded daily by the night time supervisor on the Crash Cart Readiness Checks sheet. This sheet will be kept in a binder and on the cart at all times when not in use. On the first of each month the nursing supervisor will open the cart and check the inventory, the expiration dates on the supplies and charge in the battery of the AED. The signature of the supervisor indicates that the numbered lock is secure, oxygen tank on the cart is at least ,d+[DATE] full, and the AED Rescue Ready light is green. During an observation on [DATE], at 9:16 a.m. of the GRU crash cart (a cart maintained with equipment used in cardiac emergencies) revealed the following expired supplies: - Nebulizer kit with t-piece and tubing, expired [DATE] - Nebulizer kit with t-piece and tubing, expired [DATE] - Non-rebreather mask, expired [DATE] - Suction canister, expired [DATE] - Suction canister, expired [DATE] - Size #4 King LT airway, expired [DATE] During this observation, a binder was located inside of the crash cart with a Crash Cart Checklist for [DATE]. Review of the check list sheet documentation failed to reveal that the cart was checked on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During an interview on [DATE], at 9:39 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the above observations and that the facility failed to make certain equipment was in safe operating condition for the GRU crash cart. During an observation on [DATE], at 9:50 a.m. of the Angel Wing crash cart revealed the following expired supplies: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Central line dressing kit, expired [DATE] - Two non-rebreather mask, expired [DATE] - Two nebulizer kits with t-piece and tubing, expired [DATE] - Non-conductive connecting tubing, expired [DATE] - Two 24 gauge IV (intravenous) catheters, expired [DATE] - Four IV extension kits, expired [DATE] - IV extension kit, expired [DATE] - 24 gauge IV catheter, expired [DATE] - Four 22 gauge IV catheters, expired [DATE] - Two 20 gauge IV catheters, expired [DATE] - 20 gauge IV catheter, expired [DATE] - Suction canister, expired [DATE] During this observation, the oxygen tank was observed to be empty and no Crash Cart Checklist was observed on the cart. During an interview on [DATE], at 10:33 a.m. Educator Registered Nurse (RN) Employee E3 confirmed the above observations and was unable to state where the Angel Wing crash cart checklist was located. During this interview, Educator RN Employee E3 confirmed that the facility failed to make certain equipment was in safe operating condition for the Angel Wing crash cart. During an observation on [DATE], at 9:52 a.m. of the Buttercup crash cart revealed the following expired supplies: - One gallon distilled water jug, expired [DATE] - Adult oxygen mask, expired [DATE] - Hand sanitizer, expired [DATE] - Suction tubing, expired [DATE] During this observation, the oxygen tank was observed to be empty. Review of the Crash Cart Checklist [DATE] documentation failed to reveal that the cart was checked on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE], at 10:06 a.m. RN Employee E23 confirmed the above observations and that the facility failed to make certain equipment was in safe operating condition for the Buttercup crash cart. During an observation on [DATE], at 10:12 a.m. of the Automatic External Defibrillator (AED, a portable electronic device that can automatically diagnoses and treat the life-threatening heart rhythms) located in the Restorative Dining Area revealed the AED was displaying a red X, indicating the AED was not ready for use. During an interview on [DATE], at 10:14 a.m. Licensed Practical Nurse Employee E4 stated, That is the only AED in the facility. I think it should be checked probably monthly to make sure it's not expired. During an interview on [DATE], at 10:30 a.m. Educator RN Employee E3 confirmed the AED was not in safe operating condition. 28 Pa. Code: 201.14(a) Responsibility of licensee.