STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395395	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Bend Health & Rehab Center	800 King Russ Road Harrisburg, PA 17109

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy review, clinical record review, review of select facility documentation, observation, and staff interviews, it was determined that the facility failed to ensure that the resident environment remains as free of accident hazards; and failed to provide adequate supervision and assistance devices to prevent accidents for two of 32 residents reviewed (Residents 10 and 51), which resulted in actual harm for Resident 51 as evidenced by scapholunate widening, suggesting a ligamentous injury.Findings include: Review of facility policy, titled Fall Prevention and Management Policy last reviewed July 7, 2025, read, in part, Fall risk assessments are to be completed at admission, quarterly, and as needed. Individualized interventions will be implemented based on this assessment and care planned accordingly. Providers will be consulted regarding risks and interventions, feedback, and any further approaches recommended. A fall will trigger a referral to Rehab Therapy. Review of Resident 10's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, and lack of coordination. Review of Resident 10's clinical record revealed that she had a room change on October 16, 2025. Review of Resident 10's clinical record progress notes revealed a nurse's note dated December 20, 2025, at 7:14 PM, which indicated that Resident 10 was noted to have discoloration on the right forehead and the right eye, asked resident what happened she said she bumped her head on the side rails. Review of Resident 10's clinical record progress notes revealed that she was receiving warfarin (an anticoagulant or blood thinner to help reduce risk of clot formation) daily at the time the bruising was noted, and that Resident 10's physician gave an order to hold the warfarin for one day. Review of Resident 10's clinical record failed to reveal any assessments for the safe use of enabler bars, a consent for the use of an enabler, or a physician order for an enabler. Review of Resident 10's clinical record progress notes revealed a nurse's note dated December 21, 2025, at 12:07 PM, which indicated that Resident 10 was noted to be unsteady on her feet, her pupils were not reactive to light, and that she was not responding to physical stimuli. The note further indicated that Resident 10 was sent to the emergency room for evaluation at 12:00 PM. Review of facility provided incident report for Resident 10 recorded on December 26, 2025, at 12:14 PM, indicated that on December 20, 2025, at 8:11 PM, Resident 10 was noted to have a bruise to the right side of her forehead and that Resident 10 reported that she had hit her head on the siderails. The incident report also included an interdisciplinary team note dated December 26, 2025, at 12:42 PM, that indicated Resident 10 returned to the facility on December 23, 2025, and that all testing at the hospital failed to reveal any abnormalities or acute injuries. In addition, the note indicated that physical therapy had evaluated Resident 10 upon her return to the facility and that the enabler bars were removed from the bed as Resident 10 did not demonstrate a need for them and to prevent her from hitting her head against the enabler again. During a staff interview with the Director of Nursing (DON) and Employee 5 (Regional Director of Clinical Services) on March 12, 2026, at 10:32 AM, Employee 5 confirmed that she had no enabler assessments to provide for Resident 10. She further indicated that she believed that when Resident 10 was moved upstairs that the enablers were already on the bed. Employee 5 confirmed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that the enablers should not have been on the bed. Review of Resident 51's clinical record revealed diagnoses that included age-related osteoporosis (a bone disease characterized by weak and fragile bones, increasing the risk of fractures), hypertension (high blood pressure), and abnormalities of gait and mobility (unusual patterns of walking or movement caused by injuries, neurological, musculoskeletal, or environmental factors, affecting balance, coordination, and overall mobility). Observation of Resident 51 in her room on March 9, 2026, at 10:43 AM, revealed she was wearing a brace on her right arm. Review of Resident 51's clinical record revealed she sustained a fall on February 17, 2026. Review of Resident 51's fall report dated February 17, 2026, read, in part, Resident had a fall in the shower room. The resident stated she was trying to transfer from shower chair to wheelchair. When the resident went to stand up from the shower chair it slid out and she hit the floor landing on her back. Resident has complaints of pain on right thumb. MD notified. RP notified. Nurse called into shower room for report of witnessed fall. Upon arriving, resident was noted lying flat on the floor, shower chair was to her left and the wheelchair was in front of her to the left as well. Resident initially denies any new pain other what she stated was chronic pain to her left side/hip. Resident reassessed for pain, this time complains of pain 8/10 to right hand, wrist and forearm. New orders noted to obtain STAT (immediate) 2 view X-ray of right hand, wrist and forearm. Immediate intervention was to offer resident pain medication and apply ice pack. A staff member was in the shower room with resident and was unable to stop the fall. At the time of the fall, only the front brakes of the shower chair were locked, not the back. Immediate nursing intervention was to educate staff on ensuring all brakes are locked on shower chair prior to transfers. After review, additional intervention of maintenance to inspect shower chair brakes to ensure appropriate functionality. X-ray results showed scapholunate widening suggesting a ligamentous injury (Increased distance between the scaphoid and lunate bones in the wrist. This widening typically suggests a ligamentous injury, particularly to the scapholunate ligament, which is crucial for maintaining wrist stability). Resident was immediately seen by occupational therapy to issue a brace for right wrist. Right wrist cock up splint was issued for stabilization and pain management during healing process of ligamentous injury. Review of Occupational Therapy Evaluation dated February 18, 2026, read, in part, Reason for Referral: Patient is a long term care resident seen for screening and evaluation due to Scapholunate widening s/p fall. Nurse practitioner is requesting a brace. Patient presents with deficits in range of motion, strength, fine motor and activity tolerance resulting in a decrease in a participation in ADLs (activities of daily living). Reason for Skilled Services: Patient requires skilled OT services to maximize independence w/ADLs, facilitate sitting tolerance and postural control and increase functional activity tolerance. Review of Occupational Therapy Treatment Encounter Note on February 18, 2026, read, in part, Orthotic management and training, including design and fitting, instruction in proper use, care and wearing time of prosthetic device, therapeutic stretch techniques, techniques to decrease and manage pain, techniques to improve functional skill performance and edema (fluid accumulation) reduction. Provided patient right wrist cock-up splint to stabilize wrist and prevent further injury. Patient report 10/10 pain at rest. Patient was dependent to don/doff [splint] due to pain. Review of Resident 51's physician orders revealed an active order for a brace to her right arm and an order for routine acetaminophen (pain medication). Review of Resident 51's comprehensive care plan revealed a care plan focus area Problem: Falls. History/at risk of falls, last revised March 6, 2026, with an intervention for Staff education to ensure shower chair brakes are locked prior to transfers. Interview with Employee 4 (Nurse Aide) on March 11, 2026, at 12:20 PM, revealed she was assisting Resident 51 during a transfer out of the shower chair on February 17, 2026, and as she stood up, the shower chair shot backwards and the Resident fell backwards as that happened. She further revealed she forgot to lock the back brakes of the shower chair because everything was happening very fast that day, and they absolutely should have been locked. During an interview with the DON on March 12, 2026, at 10:20 AM, she revealed she would expect the shower chair brakes to be locked as appropriate, and she would expect that the resident environment remains as free of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	accident hazards as is possible to prevent accidents. The facility failed to ensure that the resident environment remains as free of accident hazards as is possible and failed to provide adequate assistance devices to prevent accidents, which resulted in actual harm for Resident 51 as evidenced by scapholunate widening, suggesting a ligamentous injury. 201.14(a) Responsibility of licensee201.18(b)(1) Management211.10(d) Resident care policies211.12(d)(1)(2)(3)(5) Nursing services

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F 0791 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. Based on policy review, resident and staff interviews, observation, and record review, the facility failed to assist residents in obtaining timely dental services to obtain dentures for one of three residents reviewed (Resident 3), resulting in phyco-social harm and weight loss. Findings include:Review of the facility policy, titled Dental Services Policy with a last review date of January 21, 2026, revealed 12. Facility will promptly, within 3 days, refer residents with lost or damaged dentures for dental services.Review of Resident 3's clinical record revealed diagnosis that included dementia (loss of cognitive functioning that interferes with daily life) and chronic kidney disease (a long- term condition in which the kidneys gradually lose their ability to function properly).During an observation of Resident 3 on March 10, 2026, at 12:49 PM, it was revealed she was sitting in the dining room eating lunch, without her upper denture in.During an interview conducted with Resident 3 on March 12, 2026, at 1:31 PM, she revealed that it is difficult for her to eat meals due to the texture of her diet and that she would like whatever she needs done to be able to get new dentures so she can eat regular food again. Resident 3 said that she just fights through it because she doesn't know what else to do.Review of Resident 3's clinical record revealed a progress note written on December 22, 2025, at 3:36 PM, that stated her upper denture could not be located. Staff checked her room and were unable to find her denture. Review of Resident 3's care plan revealed a focus area that the resident requires assistance with oral hygiene, with an intervention to obtain a dental consult as needed, created on December 17, 2024.Review of Resident 3's physician orders revealed an order that the resident may see dentist as needed, with a start date of November 20, 2024.Review of Resident 3's clinical record revealed a speech therapy treatment encounter note on December 29, 2025, that the resident had decreased meal intake, due to dentures missing, and states to staff inability to masticate (chew) solid textures without dentures. The resident was downgraded to a puree diet (smooth, lump-free, pudding-like foods that require no chewing) at this time.Review of Resident 3's clinical record revealed a speech therapy treatment encounter note on December 30, 2025, that the resident was presented with puree diet and mechanical soft diet (nutrient-dense foods that are cooked, ground, mashed, or blended to a soft texture, requiring minimal chewing to prevent choking or aspiration) during breakfast meal, and picked to consume mechanical soft diet, however, is still without dentures and complained about inability to consume mechanical soft textures throughout session.Review of Resident 3's clinical record revealed a speech therapy treatment encounter note on December 31, 2025, that the resident was upgraded to mechanical soft diet.Review of Resident 3's clinical record revealed a speech therapy treatment encounter note on January 6, 2026, that the resident is stating to family dislike for softer diet, and that family is requesting upgrade to regular diet. Dentures continue to be missing, and trial of regular textures occurred during session. The resident expelled textures stating I can't chew that, I don't have dentures.Review of Resident 3's clinical record revealed a speech therapy treatment encounter note on January 16, 2026, that the resident prolonged mastication throughout entire session and expelled textures.Review of Resident 3's speech therapy discharge summary on January 27, 2026, revealed that mechanical soft diet is safest and least restrictive due to lack of dentures.Review of Resident 3's clinical record revealed a dental referral was not made until January 23, 2026, for the resident to receive a new top denture.Review of Resident 3's clinical record revealed that they were seen by the dentist on February 2, 2026, and had an impression done for upper complete denture.Review of Resident 3's clinical record revealed that on January 9, 2026, the resident weighed 191.6 pounds. On February 3, 2026, the resident weighed 185.4 pounds. On March 2, 2026, the resident weighed 184.2 pounds, indicating a 7.4 weight loss since her missing dentures.Interview conducted with Employee 8 (Speech Language Pathologist) on March 12, 2026, at 1:30 PM, revealed that when Resident 3's dentures first went missing the resident said she couldn't chew well. Employee 8 revealed she downgraded the residents' diet to pureed and that the resident then refused to eat. Employee 8 then changed the diet (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	to mechanical soft, and said Resident 3 is no longer on speech but she has noted when the resident is in the therapy room with other therapists if someone talks about dentures the resident will bring up the fact that she wants new dentures to eat regular food.Interview conducted with the Director of Nursing (DON) on March 12, 2026, at approximately 10:20 AM revealed she would expect residents to receive timely dental consultations for missing dentures.Pa.Code 211.5(a) - Dental Services

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on facility policy, staff interviews, and clinical record reviews, it was determined that the facility failed to provide an explanation of the risks and benefits of psychotropic medications use and obtain consent prior to administering psychotropic medications for three of five residents reviewed for psychotropic medication use (Residents 7, 10, and 66).Findings include: Review of facility provided policy, titled Psychoactive Medication Policy, last reviewed April 30, 2025, failed to reveal any expectation of obtaining consent prior to starting psychoactive medications. Review of Resident 7's clinical record revealed diagnoses that included major depressive disorder (a serious, common mood disorder characterized by persistent sadness, loss of interest, and fatigue, lasting at least two weeks and impairing daily life) and dementia (a general term for severe mental function loss). Review of Resident 7's physician orders revealed an order for Trazodone (medication used to treat depression) 75 mg, given by mouth three times daily for depression, starting on February 13, 2026. Further review revealed an order for Lorazepam (antianxiety medication) 0.5 mg twice daily for anxiety, starting on December 16, 2025. Review of Resident 7's Care plan revealed a focus of: Psychotropic drug use, Resident receives antidepressant and antianxiety medication, with a start date of July 9, 2024. Review of Resident 7's medical record failed to reveal an explanation for the risks and benefits of psychotropic medications and consent for use of those medications by Resident 7 or their representative. Interview with the Director of Nursing (DON) on March 12, 2026, at 10:45 AM, revealed that Resident 7 did not have the appropriate notifications made prior to starting psychotropic medications. Review of Resident 10's clinical revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and depression. Review of Resident 10's physician orders from admission through current revealed orders for: quetiapine (an antipsychotic medication) 25 mg administer one tablet at bedtime from July 19, 2025-August 19, 2025; Rexulti (an antipsychotic medication) 0.5 mg started on August 20, 2025, increased to 1 mg on August 26, 2025, and discontinued on January 8, 2026; mirtazapine (medication used to treat depression) 15 mg administer one tablet daily from July 18, 2025, through current; and trazodone (medication used to treat depression) 50 mg give half a tablet three times a day dated January 14, 2026. Review of Resident 10's care plan revealed a focus of: Psychotropic drug use, Resident receives antipsychotic medication, with a start date of July 29, 2025; and Psychotropic drug use, resident receives antidepressant medication, with a start date of November 11, 2025. Review of Resident 10's medical record failed to reveal an explanation for the risks and benefits of psychotropic medications and consent for use of those medications by Resident 10 or their representative. During a staff interview with the DON and Employee 5 (Regional Director of Clinical Services) on March 12, 2026, at 11:03 AM, Employee 5 indicated that the facility had no psychotropic medication consents to provide for Resident 10. Review of Resident 66's clinical record revealed diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression, and dementia. Review of Resident 66's physician orders revealed orders for aripiprazole (an antipsychotic medication) 2 mg one tablet give with aripiprazole 5 mg one tablet for a total dose of 7 mg at bedtime, dated March 6, 2026; bupropion (medication used to treat depression) 300 mg extended release tablet give one tablet daily in the morning, dated December 4, 2025, and escitalopram (medication used to treat depression) 10 mg give one tablet daily, dated December 4, 2025. Review of Resident 66's care plan revealed a focus of: Psychotropic drug use, Resident receives antidepressant, antipsychotic, and mood stabilizer, with a start date of March 20, 2025. Review of Resident 66's medical record failed to reveal an explanation for the risks and benefits of psychotropic medications and consent for use of those medications by Resident 66 or their representative. During a staff interview with the DON and Employee 5 on March (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12, 2026, at 11:03 AM, Employee 5 indicated that the facility had no psychotropic medication consents to provide for Resident 66. 28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on policy review, resident interviews, facility documentation review, and staff interviews, it was determined that the facility failed to make prompt efforts to resolve grievances the resident may have for six grievances reviewed (Residents 35, 41, 43, 59, 66, and 157).Findings include: Review of the facility policy, titled Resident Grievances and Concerns Policy with a last review and revision date of May 8, 2025, revealed 4. The grievance review will be completed in a reasonable time frame consistent with the type of grievance, but in no event will the review exceed thirty (30) days. If the grievance committee / Grievance official determines that a resident rights violation has occurred, the violation must be corrected within ten (10) days. If the resident right violation cannot be corrected within 10 days, the Grievance official shall refer the matter to the State Department of Health. Interview conducted with Residents 4, 41, 59, 108, and 157 during Group with Resident Council on March 10, 2026, at 11:00 AM, revealed that grievances do not always get resolved timely or at all by the facility. Residents reported missing clothing items that they have filed a grievance for and have not been found or replaced. During Group, Resident 41 revealed the Resident has been missing a pair of pants since January 2026, and Resident 157 revealed the Resident was missing three pairs of slacks and two shirts, which were brand new. Resident 157 revealed staff took them out of his room and never returned them. Interview conducted with the Nursing Home Administrator and Director of Nursing (DON) on March 11, 2026, at 11:17 AM, revealed they will follow up with Resident 41 and Resident 157 on their missing clothing concerns. Review of a Concern Form completed on November 11, 2025, pertaining to Resident 35, 43, 59, and 66, revealed they are not getting clothes back. Documentation of the concern revealed that most, if not all of the clothes, were labeled with the resident's name, which included the following: Resident 35- one sweat suit with a zip top and five sports bras; Resident 43- two pajama sets and four pairs of gripper socks; Resident 59- two long sleeve sweat shirts and two pairs of dress pants; Resident 66- one pair of new jeans. Resolution of the grievance, dated November 13, 2025, revealed that the concern was not resolved, and only some laundry was returned and was still in search of others. The residents voicing concern were not satisfied with the resolution as they were still missing items. Interview conducted with DON on March 12, 2026, at approximately 10:20 AM, revealed they were unable to provide any further information on whether any additional efforts were made to locate the Residents' reported missing clothing or that they have been replaced. The DON was unable to provide any information on whether there was any follow-up completed or grievance made for Resident 41 and 157 related to their missing clothing concerns. 28 Pa code 201.18(b)(2)(3) Management28 Pa code 201.29(a) Resident rights

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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** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 31 residents reviewed (Residents 10, 11, and 66).Findings include: Review of Resident 10's clinical revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and depression. Review of Resident 10's physician order history revealed an order for Rexulti (an antipsychotic medication) 1 mg administer one tablet daily, dated August 26, 2025. Review of Resident 10's psychiatry consult note dated October 24, 2025, which indicated that no gradual dose reduction (GDR) of Resident 10's antipsychotic medication should be attempted as the benefits of the medication outweigh the risks. Review of Resident 10's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of December 29, 2025, indicated in Section N. Medications at question N0450. Antipsychotic Medication Review that Resident 10's physician had not documented a GDR as clinically contraindicated. During a staff interview with Employee 5 (Regional Director of Clinical Services) on March 11, 2026, at 11:37 AM, Employee 5 indicated that Resident 10's MDS was not coded accurately and that she would expect the MDS to be an accurate reflection of the Resident's status. Employee 5 further indicated that a modification to the assessment would be completed. Review of Resident 11's clinical record revealed diagnoses that included hypertension (high blood pressure) and obesity. Review of Resident 11's clinical record revealed that she was readmitted to the facility on [DATE], after a hospital stay and that she was noted to have a Stage 2 pressure ulcer (a partial-thickness skin injury presenting as shallow open wound with a red or pink moist wound bed without exposure of fat or deeper tissues), a Stage 3 pressure ulcer (full-thickness skin injury with visible subcutaneous fat or dead tissue that appears yellow, white, or gray called slough), and a Stage 4 pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle and may have slough or dry black firm tissue adhered to the wound bed called eschar present). Review of Resident 11's Quarterly MDS with the assessment reference date of December 2, 2025, revealed in Section M. Skin Conditions that Resident 11 had a Stage 2 and a Stage 3 pressure ulcer present upon admission and a Stage 4 pressure ulcer that was not present upon admission. Review of Resident 11's Quarterly MDS with the assessment reference date of January 22, 2026, revealed in Section M. Skin Conditions that Resident 11 had a Stage 4 pressure ulcer that was not present upon admission. During a staff interview with the Director of Nursing (DON) and Employee 5 on March 11, 2026, at 11:47 AM, Employee 5 confirmed Resident 11's pressure ulcers were present upon admission and that Resident 11's MDS's were coded inaccurately. Employee 5 further indicated that she would expect the MDS to be an accurate reflection of the Resident's status and that modifications would be completed. Review of Resident 66's clinical record revealed diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression, and dementia. Review of Resident 66's Medication Administration Record for May 2025, revealed that he received his ordered antipsychotic, antidepressant, anticonvulsant, and diuretic medications. Review of Resident 66's Annual MDS with the assessment reference date of May15, 2025, revealed in Section N. Medications that he only received an antibiotic and insulin during the reference period. Review of Resident 66's psychiatry consult note dated October 24, 2025, which indicated that no GDR of Resident 66's antipsychotic medication should be attempted as the benefits of the medication outweigh the risks. Review of Resident 66's Quarterly MDS with the assessment reference date of December 29, 2025, indicated in Section N. Medications at question N0450. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Antipsychotic Medication Review that Resident 66's Physician had not documented a GDR as clinically contraindicated. During a staff interview with the DON and Employee 5 on March 11, 2026, at 10:29 AM, Employee 5 confirmed that Resident 66's MDS's were not coded accurately and that she would expect the MDS to be an accurate reflection of the Resident's status. Employee 5 further indicated that modifications to the assessments would be completed. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, facility policy review, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for three of 32 residents reviewed (Residents 10, 99, and 149). Findings include: Review of facility policy, titled Comprehensive Care Planning Policy, last reviewed February 24, 2026, revealed, An interdisciplinary plan of care will be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. Review of Resident 10's clinical revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and atrial flutter (abnormal heart rhythm that occurs when the upper heart chambers beat faster than normal). Review of Resident 10's care plan revealed a focus of Psychotropic drug use, Resident receives antipsychotic medication and focus of Cardiovascular Anticoagulant therapy, with start dates of July 29, 2025. Review of Resident 10's clinical record revealed that her antipsychotic medication was discontinued on January 8, 2026, and her anticoagulant medication was discontinued on December 31, 2025. During a staff interview with the Director of Nursing (DON) and Employee 5 (Regional Director of Clinical Services) on March 12, 2026, at 10:31 AM, the DON confirmed that Resident 10's care plan should have been revised when her medication changes occurred and further indicated she revised the care plan that morning. Review of Resident 99's clinical record revealed diagnoses that included repeated falls and muscle weakness (weakness in the muscles not explained by any medical diagnosis). Observation of Resident 99 on March 9, 2026, at 10:25 AM, revealed Resident 99 lying in bed and there were fall mats on the floor on both sides of their bed. Review of Resident 99's care plan revealed a care plan of: Resident has a history of falling related to admission to facility, history of falls, with a start date of January 18, 2024. Further review failed to reveal any indication to use fall mats on the floor on both sides of Resident 99's bed. An interview with the DON on March 12, 2026, at 11:15 AM, revealed that Resident 99's care plan should have included the use of bilateral fall mats while in bed. Review of Resident 149's clinical record revealed diagnoses that included peripheral vascular disease (common condition characterized by narrowed arteries that reduce blood flow to the limbs) and spinal stenosis (narrowing of one or more spaces within the spinal canal). Observation of Resident 149 on March 9, 2025, at 12:18 PM, revealed the Resident lying in bed. During an interview with Resident 149 at that time, she stated five times that she was just there waiting for a family member to pick her up and take her home. Review of Resident 149's care plan failed to reveal any indication of whether Resident 149's goal was to receive care at the facility long term or be discharged to another level of care. Review of Resident 149's care conference notes dated December 11, 2025, revealed that Resident 149 would like to go home by herself, she has been educated that her physician feels that is not safe for her. Discussed potential for assisted living, resident declined. An interview with the DON on March 12, 2026, at 11:15 AM, revealed that Resident 149's care plan should have included her choice for discharge or long-term care at the facility. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. Based on review of facility contract, review of select facility documentation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents receive proper treatment and assistive devices to maintain vision or hearing abilities for one of three resident's reviewed for vision and hearing (Resident 8). Findings include: Review of agreement between the facility and contracted vision services company with an effective date of December 14, 2018, read, in part, During the term of this agreement the company agrees to arrange the following services to the residents of the facility.optometry services, which may include vision examinations, medical eye evaluations, fitting and ordering of eye glasses, and adjustment of eye glasses. Facility shall assist in coordinating receipt of any proper documentation or orders from a resident's attending physician that may be required prior to rendering services. Review of Resident 8's clinical record revealed diagnoses that included Nonexudative age-related macular degeneration (a common eye condition that leads to gradual vision loss, primarily affecting central vision due to the deterioration of the macula), dysphagia (difficulty chewing and/or swallowing), and delusional disorders (a serious mental health condition characterized by persistent, false beliefs that are not based in reality, often leading to significant distress and impairment in functioning). During an interview with Resident 8 in his room on March 9, 2026, at 1:56 PM, he revealed his glasses were three years old and he was unable to see out of them. Review of Resident 8's comprehensive care plan revealed a focus area Resident has impaired vision with an intervention for ophthalmologist/optometrist consult, as per orders. Review of Resident 8's vision consult from November 26, 2024, read, in part, Nonexudative age-related macular degeneration, bilateral. Please schedule consult with a retinal specialist for evaluation and treatment options. New spectacles recommended to maximize visual function. Review of Resident 8's vision consult from February 5, 2025, read, in part, Patient reports that he did not get glasses from November order, did not see a retinal specialist, and is not receiving any [drops]. Nonexudative age-related macular degeneration, bilateral. Please schedule consult as recommended on November 26, 2024, for additional testing, evaluation, and treatment options. Review of Resident 8's vision consult from June 17, 2025, read, in part, Patient reports not receiving new glasses. Patient also states he did not see a retinal specialist as recommended last visit. Please schedule consult with retinal specialist for evaluation and treatment of possible CNM (Choroidal Neovascular Membranes- abnormal blood vessels that grow beneath the retina, often leading to vision loss and are commonly associated with age-related macular degeneration). During an interview with the Director of Nursing (DON) on March 12, 2026, at 10:17 AM, she revealed the initial consult and February consult recommendations that were missed were prior to current facility ownership and she cannot speak to why they were missed, but the recommendations have also been missed in the follow up visit in June 2025 during current facility ownership. She revealed Resident 8 has since been admitted to hospice services in July 2025, so they will follow up with the physician to determine if the recommendations are still indicated. The DON revealed it is her expectation that contracted service recommendations are implemented or responded to by the physician if in disagreement. 28 Pa. Code 201.18(b)(1) Management28 Pa Code 211.12(d)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen and in two of two pantry refrigerators (first and second floors). Findings include: Review of facility policy, titled Food Brought in From Outside the Facility, last reviewed November 18, 2024, read, in part, when residents or their friends or family bring food into the facility the container will be labeled with name of the food item, resident name, dated and placed in an appropriate refrigerator. Review of facility policy, titled Storing Dry Food, last reviewed March 28, 2025, read, in part, food will be stored six inches above the floor. When original packaging is opened, food must be stored in containers that can be sealed and covered. Observation in the dry storage room on March 9, 2026, at 9:44 AM, revealed one package of dried chicken gravy wasn't securely closed or date marked. At that time, Employee 9 (Food Service Director) revealed that the package should've been securely closed and marked with an open date. Observation in the walk-in refrigerator on March 9, 2026, at 9:49 AM, revealed one plastic container of fresh sweet potatoes not marked with a date. At that time, Employee 9 revealed the container of sweet potatoes should be date marked. Observation in the walk-in freezer on March 9, 2026, at 9:48 AM, revealed one case of crescent rolls was on the floor, open with one tray removed from the case. At that time, Employee 9 revealed the case of crescent rolls should not be on the floor. Observation in the first-floor nourishment refrigerator on March 9, 2026, at 10:00 AM, revealed one plastic container of soup, one Styrofoam container of French fries with cheese sauce, one Styrofoam container with a chicken fajita, and one plastic container of taco salad were not marked with a resident identifier or date. At that time, Employee 9 revealed the aforementioned items should've been marked with a resident identifier and a date. Observation in the second-floor nourishment refrigerator on March 9, 2026, at 10:06 AM, revealed two 32-ounce containers of Med Pass 2.0 (high calorie nutritional supplement) were open with contents partially removed and weren't date marked. At that time, Employee 10 (Regional Registered Dietitian) revealed the containers should've been marked with a date when opened. Interview with the Nursing Home Administrator (NHA) on March 11, 2026, at 11:00 AM, the surveyor discussed the aforementioned concerns pertaining to food storage, and the NHA provided no further information. 28 Pa code 211.6(f) - Dietary Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, facility policy review, and staff interview, it was determined that the facility failed to ensure staff implement infection control policies to prevent the spread of infection for one of two employees observed during medication pass (Employee 2) Findings Include: Review of facility policy, titled General Dose Preparation and Medication Administration, revised November 15, 2024, revealed that, prior to preparing or administering medications, facility staff should complete appropriate hand hygiene. Observation of Employee 2 (Registered Nurse) on March 10, 2026, at 9:41 AM, revealed Employee 2 administering medications to Resident 92, then Resident 100, then Resident 93, and finally Resident 12 without completing hand hygiene at any time during the observation. Interview with the Director of Nursing on March 3, 2026, at 12:15 PM, revealed that she would expect Employee 2 to complete hand hygiene as needed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. Based on review of facility policy, observations, clinical record review, and staff interview, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 32 residents reviewed (Resident 149). Findings include: Review of the facility policy, titled Resident Rights and Facility Responsibilities, revised September 3, 2020, revealed it is the facility's policy to comply with all Residents Rights, and to communicate these rights to residents and their designated representatives in a language that they understand. Review of Resident 149's clinical record revealed diagnoses that included peripheral vascular disease (common condition characterized by narrowed arteries that reduce blood flow to the limbs) and spinal stenosis (narrowing of one or more spaces within the spinal canal). Observation of Resident 149's room on March 9, 2026, at 12:17 PM, revealed a dry-erase board hanging on her wall marked that it was February 2026. Further observation revealed a calendar hanging on the wall that was open to the month of July 2025. Review of Resident 149's care plan revealed a problem area of, Psychosocial Well-Being, at risk for social isolation related to admission to the facility with a start date of January 27, 2025, and an approach of, provide activity calendar, with a start date of July 31, 2025. Review of Resident 149's Quarterly MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated February 2, 2026, revealed a BIMS (Brief Interview for Mental Status - Summary Score ranges from 0 to 15 and reflects a resident's cognitive function, including memory and orientation, with higher scores indicating better cognitive performance) summary score of 12. Interview with the Nursing Home Administrator on March 11, 2026, at 12:35 PM, revealed that she would expect the nursing or activities staff to update the dry-erase board and have the calendar on the correct month. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, Resident Council Meeting minutes, and resident and staff interviews it was determined the facility failed to consider the views of residents and act promptly on concerns regarding quality of life and issues with wandering residents entering other resident's rooms for three of three months (December 2025, January 2026, and February 2026). Findings include:Review of the facility policy, titled Resident Council Policy with a last revised and review date of March 31, 2025, revealed B. 2. The Activity Director will attempt to accommodate the resident recommendations to the extent practicable and provide follow-up to the Resident Council, and E. Resident issues or concerns will be documented on the Resident/Family Concern form and forwarded to the facility Administrator for the appropriate follow-up.Review of facility provided Resident Council Meeting minutes dated December 9, 2025, documented an issue/concern regarding confused residents going into other resident rooms late at night; no resolution documented. The meeting held on January 13, 2026, documented the concern with confused residents wandering and removing items from other residents' rooms. The documented resolution was to provide education reminders to staff to complete purposeful rounds, checking the location of the confused residents and redirecting them out of other resident rooms. Review of the February 2026 Resident Council Meeting Minutes failed to document review of the concern regarding wandering residents from the January meeting to ensure the concern was resolved.Interview with Resident 59 on March 9, 2026, at 11:42 AM revealed concern with residents being moved from the Dementia unit to E- hall. She stated that those residents are confused, roam the hallways and come into her room. She noted that the confused residents are becoming more agitated and hostile when she tells the resident to leave her room or items they are attempting to take are not theirs. She was ambulating in her wheelchair in the hallway and one of the confused residents grabbed her chair from behind and started to push her and a staff member had to intervene.Interview with Resident 98 on March 9, 2026, at 11:09 AM revealed concern with the dementia unit being closed and the residents being moved E- hall. She stated that the confused residents roam into other resident rooms and attempt to take items that don't belong to them and have taken food off her meal tray. Interview with Resident 101 on March 9, 2026, at 11:05 AM revealed concern with the dementia unit being closed and the residents being moved E- hall. She stated that one confused resident wander into her room frequently and she stated, I think, she thinks I'm her mother and she takes her cheese curls. It was revealed she hasn't completed a concern/grievance form. It was also revealed that she doesn't get out of her bed, by her choice.Interview with the Nursing Home Administrator (NHA) on March 10, 2026, at 2:14 PM revealed that an additional activities staff member has been hired and the hours have been extended to include later on the evening shift. There also are additional activity programs held on second floor.During group interview conducted on March 10, 2026, at 11:00 AM, the following residents: 4, 41, 59, 108, and 157 revealed concerns that residents will wander in their rooms all the time, every day, and will hit and steal from residents, with minimal staff intervention. Resident reported that staff will just tell those residents to move on. The residents revealed that they suggested during the February 2026 Resident Council Meeting about getting signs to put across resident rooms that say stop to mitigate residents from wandering into their rooms and disrupting them, however have not yet received the signs or heard a response from the facility for that request.Interview with residents 59 and 98 on March 11, 2026, at 11:24 AM it was revealed that the concern regarding residents wandering into resident rooms was discussed at resident council meeting monthly since December 2025 and were told Administration would look into it. They recalled the discussion of the use of stop signs, however, couldn't recall when that discussion took place, and it was confirmed that a stop sign has not been offered to them.Interview with the NHA on March 11, 2026, at 10:45 AM it was revealed that the facility purchased stop signs to be hung across resident doorways to minimize wandering residents from entering other resident rooms. It was revealed the order was placed March 11, 2026. Review of the (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order summary documented the order was placed March 11, 2026, for door guard stop banner stop sign strip do not enter sign.28 Pa. Code 201.18(e)(4) Management28Pa. Code 201.29(i) Resident Rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on facility policy review, observations, and staff interview, it was determined that the facility failed to maintain a safe, clean, comfortable and home-like environment in two of eight hallways observed. Findings include: Review of facility policy, titled General Routine Environmental Cleaning and Disinfection Policy last reviewed July 2, 2026, read, in part, Proper cleaning and disinfecting of environmental surfaces is necessary to break the chain of infection. Cleaning refers to the removal of visible soil from surfaces through the physical action of scrubbing with detergents/surfactants and rinsing with water. Household surfaces should be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled (floors, tabletops, resident care areas, dining rooms, common areas, shared shower rooms and bathrooms, hair salons, activities, etc). Observation in Resident 8's room on March 9, 2026, at 12:53 PM; March 10, 2026, at 12:56 PM, and March 11, 2026, at 10:18 AM; revealed his tray table was dirty and had spilled liquid, and his floor was dirty and had a discarded plastic cup, consistent as the day before. Observation in Resident 51's room on March 9, 2026, at 10:43 AM; March 10, 2026, at 9:29 AM, and March 11, 2026, at 10:20 AM; revealed the floor appeared heavily soiled, and had a straw wrapper and a pepper packet on the floor, consistent as the day before. Observation in Resident 115's room on March 10, 2026, at 9:23 AM, revealed his tray table was heavily soiled with debris and spilled liquid stains. Observation in Resident 115's room on March 11, 2026, at 10:25 AM, revealed his tray table was heavily soiled with debris and spilled liquid stains, consistent as the day before.During an interview with the Nursing Home Administrator on March 11, 2026, at 1:33 PM, she revealed the concerns were addressed in the resident rooms and that they have been having issued with oversight in the housekeeping department. She further revealed she would expect the facility to provide housekeeping services necessary to maintain a safe, clean, comfortable and home-like environment. 28 Pa. Code 201.18(e)(2.1) Management

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy review, clinical record review, review of facility provided documentation, and staff interviews, it was determined that the facility failed to provide written notice of a resident's transfer to the resident and the resident's representative for two of six residents reviewed for hospital transfer (Residents 10 and 56); failed to send notice of a residents transfer to a representative of the Office of the State Long-Term Care Ombudsman for two of six residents reviewed for hospital transfers (Residents 10 and 56); and failed to provide a written copy of the facility's bed-hold policy for three of six residents reviewed (Residents 8, 10, and 56).Findings include: Review of facility policy, titled Discharge Planning Policy, last reviewed February 3, 2026, revealed, in part, Transfers and discharges will meet regulatory requirements. Further review of the policy failed to reveal the requirement that a resident and their representative, as well as a representative of the Office of the State Long-Term Care Ombudsman, were to be provided with written notice of the transfer. Review of facility policy, titled Bed Hold Letter Policy, dated March 24, 2025, revealed, in part, It is the policy of the facility to track Medicaid bed hold days and notify appropriate parties via Medicaid Bed Hold Letter. The Business Office Manager will compare bed hold tracking log to monthly census report to verify accuracy of bed holds recorded and letters sent. Business Office manager or designee will complete the Medicaid Bed Hold Letter and send to the appropriate parties certified/return receipt requested. The Medicaid Bed Hold Letter can be given directly to the responsible party if they are present. Medicaid copy will be retained in resident's financial file. Review of Resident 8's clinical record revealed diagnoses that included muscle weakness, dysphagia (difficulty chewing and/or swallowing), and delusional disorders (a serious mental health condition characterized by persistent, false beliefs that are not based in reality, often leading to significant distress and impairment in functioning). Review of Resident 8's clinical record revealed that he was transferred to the hospital on July 7, 2025. Review of Resident 8's clinical record failed to reveal that a written notice of the facility's bed-hold policy was provided to Resident 8 or his representative. During a staff interview with the Director of Nursing (DON) and Employee 5 (Regional Director of Clinical Services) on March 12, 2026, at 10:23 AM, Employee 5 indicated that she had no additional information to provide for Resident 8's bed-hold notice. The DON revealed she would expect bed hold notices to be available and sent to a resident or their representative in the event of a hospitalization. Review of Resident 10's clinical revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and atrial flutter (abnormal heart rhythm that occurs when the upper heart chambers beat faster than normal). Review of Resident 10's clinical record revealed that she was transferred to the hospital on December 21, 2025. Review of Resident 10's clinical record failed to reveal that a written notice of her transfer or a written notice of the facility's bed-hold policy was provided to Resident 10 or her representative. Review of facility provided documentation of Ombudsman reporting for the month of December 2025, failed to include Resident 10. During a staff interview with the DON and Employee 5 on March 11, 2026, at 11:31 AM, Employee 5 indicated that she had no additional information to provide for Resident 10's written notice of transfer and the facility bed-hold policy. As of the time of exit, interview with the DON and Employee 5 on March 12, 2025, at 2:00 PM, no additional information was provided by the facility regarding the Ombudsman reporting for Resident 10's hospital transfer. Review of Resident 56's clinical record documented diagnoses that included fractured pelvis, spinal stenosis (narrowing of the spaces within the spine, causing pain, numbness or weakness), and chronic obstructive pulmonary disease (inflammatory disease obstructing airflow making it difficult to breathe). Further review of Resident 56's clinical record documented he was transferred to the hospital on January 23, 2026, and returned to the facility on January 28, 2026. At the time of transfer, the Resident's payor source was Medicaid. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 56's clinical record failed to reveal that a written notice of his transfer or a written notice of the facility's bed-hold policy was provided to Resident 56 or his representative. Interview with the Nursing Home Administrator on March 11, 2026, at 11:33 AM, revealed the facility didn't have proof of a written notice of transfer and the bed hold policy was provided to the Resident or responsible party, or that the Ombudsman was notified. 28 Pa. Code 201.14(a) Responsibility of licensee.

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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. Based on observations, facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure a resident's comprehensive care plan was implemented for one of 31 residents reviewed (Resident 10).Findings include: Review of facility policy, titled Comprehensive Care Planning Policy, reviewed February 24, 2026, revealed, in part, All staff caring for the resident will be familiar with the resident's plan of care. Review of Resident 10's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, and lack of coordination. Review of Resident 10's care plan revealed a focus of Behavioral Symptoms Resident experiences wandering activity throughout hallways and occasionally into resident rooms, with a start date of January 27, 2026. Interventions included, but were not limited to, Provide visual deterrents such as stop signs, warning signs, arrows, or do not enter signs on appropriate locations; Remove Resident from other resident's rooms and unsafe situations; and when Resident begins to wander, assess for comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.), all dated January 27, 2026. Observation of Resident 10 on March 9, 2026, at 10:49 AM, revealed she was wandering room to room in the hall where she resided. She was noted to enter Resident 64's room. Resident 64 was sitting in her wheelchair. Resident 10 picked up Resident 64's Styrofoam water cup and Resident 64 called out at her Hey. Resident 10 then dropped the cup on the floor. At the time of observation of Resident 10's wandering, three staff members (nurse aides) were present in the hallway, one of which was seated in chair outside of Resident 78's room. When the surveyor approached this staff member to share the observation of water being spilled, she indicated I saw it. During a staff interview with Employee 7 (Nurse Aide) on March 9, 2026, at 10:55 AM, Employee 7 indicated that Resident 10 always wanders room to room and stated, it is just what she does, and made no attempt to redirect her. Observation of Resident 10 on March 10, 2026, at 10:03 AM, revealed there was an activity noted to be occurring in the central area by the nurse's station. Resident 10 was wandering the hall in which she resided, closing all open resident room doors. There were two staff noted in the hall (a nurse and a nurse aide) and neither staff were attempting to redirect her. In addition, observations on March 9-12, 2026, failed to reveal any visual deterrents such as stop signs, warning signs, arrows, or do not enter signs on appropriate locations on the hallway where Resident 10 resided. During a staff interview with the Director of Nursing and Employee 5 (Regional Director of Clinical Services) on March 12, 2026, at 10:37 AM, Employee 5 confirmed that the facility had not placed any stop signs and that the facility had just ordered them. She further indicated that facility staff should have been following Resident 10's care plan. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10(d) Resident care policies28 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
	395395	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Bend Health & Rehab Center	800 King Russ Road Harrisburg, PA 17109

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good grooming and personal hygiene for one of seven residents reviewed for ADLs (Resident 51). Findings Include:Review of the facility policy, titled AM Care Policy last reviewed September 16, 2025, read, in part, Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing. Showers and baths are scheduled two times weekly or more or less according to resident preference. Provide shaving as desired by resident.Review of Resident 51's clinical record revealed diagnoses that included age-related osteoporosis (a bone disease characterized by weak and fragile bones, increasing the risk of fractures), hypertension (high blood pressure), and abnormalities of gait and mobility (unusual patterns of walking or movement caused by injuries, neurological, musculoskeletal, or environmental factors, affecting balance, coordination, and overall mobility).Observation of Resident 51 in her room on March 9, 2026, at 10:43 AM; March 10, 2026, at 9:29 AM, and March 11, 2026, at 10:20 AM; revealed she had a quarter inch presence of facial hair on her chin.Review of Resident 51's physician orders revealed she had a preferred bathing schedule of Tuesdays and Fridays on day shift. Review of Resident 51's comprehensive care plan revealed a focus area ADL/self care/mobility deficits, with an intervention for personal hygiene/grooming assist of 1.Review of Resident 51's point of care documentation revealed she was documented as receiving a bed bath on Tuesday March 10, 2026, and required a level of assistance of total dependence. Interview with Resident 51 on March 11, 2026, at 10:20 AM, she revealed she prefers to have bed baths in her room, and the staff does not always offer to shave her. Interview with the Director of Nursing on March 12, 2026, at 10:20 AM, revealed Resident 51 has been shaved, and she would expect ADL care to be provided to dependent residents and shaving to be offered on bathing days and as needed. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 31 residents reviewed (Resident 66).Findings include: Review of facility policy, titled Administration of an Intermittent Infusion, with a last revised date of June 1, 2021, revealed, in part, Flush vascular access device with prescribed flushing/locking agent(s) to maintain patency between intermittent infusions. Review of facility policy, titled Short Peripheral Intravenous Catheter (PIVC) Dressing Change, with a last revised date of June 2024, revealed, in part, Transparent dressings are changed with each site rotation every seven days, or sooner if the integrity of the dressing is compromised (wet, loose or soiled). Assessment of peripheral catheter site is performed: 5.3 Before and after administration of intermittent infusions 5.4 At least once every shift when not in use 5.5 Routinely for signs and symptoms of infiltration and extravasation at a frequency based on patient condition, age, type of medication, and rate of flow. Label dressing with: 21.1 Date and time of dressing change 21.2 Nurse's initials. Review of Resident 66's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and urinary tract infection. Review of Resident 66's clinical record revealed that he was readmitted to the facility on [DATE], after a hospital stay. Review of Resident 66's physician orders revealed an order for meropenem 1 gram in 100 milliliters of 0.9% normal saline intravenously twice a day over 3 hours, dated March 6, 2026. Further review of orders failed to reveal any orders for a flushing/locking agent(s), peripheral access site changes, or intravenous access site dressing changes. Observations of Resident 66 on March 9, 2026, at 1:15 PM, and March 10, 2026, at 1:25 PM, revealed an intravenous access line in the antecubital area of his left forearm. The dressing was intact, but no date was present. Resident 66 indicated that he had that from the hospital. Review of Resident 66's hospital records failed to reveal any documentation regarding when the intravenous access site was started or when the dressing was changed. Review of Resident 66's Admission/readmission Observation dated March 6, 2026, at 5:06 PM, revealed in the Infectious Disease section that Resident 66 had a urinary tract infection and that orders were reviewed with Resident 66's physician. The assessment failed to include any documentation of the presence of an intravenous access site. In addition, the baseline care plan section failed to include Resident 66 had a current infection requiring enhanced barrier precautions or his intravenous access site and care. During a staff interview with the Nursing Home Administrator, Director of Nursing (DON), and Employee 5 (Regional Director of Clinical Services) on March 11, 2026, at 11:14 AM, the DON and Employee 5 confirmed that orders should have been in place for a flushing agent, intravenous access site changes and dressing changes when Resident 66 was readmitted to the facility on [DATE]. In addition, both confirmed that Resident 66's baseline care plan should have included his infection, isolation precautions, and his intravenous access site. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.9(a)(1) Pharmacy services.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 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. Based on facility policy review, observations, clinical record review, and staff interviews, it was determined the facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications for one of one resident reviewed for tube feeding (Resident 115). Findings include: Review of facility policy, titled Enteral Feeding Tube Policy last revised April 1, 2016, read, in part, Licensed clinicians with demonstrated competence may administer enteral feedings and provide tube/site care. Review of Resident 115's clinical record revealed diagnoses that included gastrostomy status (refers to the presence of an artificial opening in the stomach for feeding patients who cannot ingest food orally), unspecified protein-calorie malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it gets), and dysphagia (difficulty chewing and/or swallowing). Review of Resident 115's physician orders revealed an order for Enteral: Pump Feeding up at 6:00 PM Special Instructions: At 6:00 PM hang (Isosource 1.5- tube feeding formula). Confirm rate programmed at (85 ml/hr), confirm total volume programmed in at 1360ml. Further review of Resident 115's physician orders revealed an order to take down the tube feeding at 10:00 AM daily. Review of Resident 115's comprehensive care plan revealed a focus area Nutritional status: dysphagia, calorie protein malnutrition, need for feeding tube, with an intervention for provide tube feeding supplement with water flushes as ordered, with a start date of February 22, 2026. Observation in Resident 115's room on March 10, 2026, at 9:23 AM, revealed his enteral feeding bag was hanging up and being infused and the bag was not labeled with a hang time or date. Further observation of the bag revealed a use by date of March 4, 2026. The bag read, Use for a maximum of 48 hours after connection when proper technique is followed. Observation in Resident 115's room on March 10, 2026, at 10:26 AM, revealed his enteral feeding bag was hanging up, almost empty, but not currently infusing. The aforementioned bag was not labeled with a hang time or date. Further observation of the bag revealed a use by date of March 4, 2026. The bag read, Use for a maximum of 48 hours after connection when proper technique is followed. During an interview with Employee 3 (Registered Nurse) on March 10, 2026, at 10:37 AM, revealed the aforementioned bag was the same bag she disconnected from Resident 115's tube feeding pump, but she was not the one that hung the bag up the day before. During the interview, Employee 3 was made aware of the expired tube feeding formula. She found two other bags of formula in a box in his room that were also expired and revealed she would look into finding new formula. Interview with the Director of Nursing on March 11, 2026, at 11:31 AM, revealed she would expect utilized tube feeding formulas to be labeled with a hang time and date and not to be expired. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on facility policy review, medication administration observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate of less than five percent (4 errors in 25 observations, 15.38%).Findings include: Review of facility policy, titled General Dose Preparation and Medication Administration, revised November 15, 2024, revealed that prior to administering medication the nurse should verify that the medication to be administered is the correct medication, at the correct dose, for the correct resident. Review of Resident 66 current physician orders revealed medication orders for Cyanocobalamin (Vitamin B-12) 1000 mcg daily, starting on March 6, 2026. Observation on March 10, 2026, at 9:41 AM, revealed Employee 1 (Licensed Practical Nurse- LPN) was observed administering Cyanocobalamin 500 mcg to Resident 66. Review of Resident 93's current physician orders revealed medication orders for Cyanocobalamin (Vitamin B-12) 4000 mcg daily, starting October 1, 2025; Aspirin 81 mg chewable tablet, starting October 1, 2025; and Senna 8.6 mg twice daily, starting November 26, 2025. Observation on March 10, 2026, at 9:41 AM, revealed Employee 2 (Registered Nurse- RN) was observed administering the following medications to Resident 93: Senna Plus 8.6 mg-50 mg (Senna 8.6 mg and docusate 50 mg); Aspirin 81 mg enteric coated; and Cyanocobalamin 500 mcg. During an interview with the Director of Nursing on March 10, 2026, at 12:15 PM, she revealed that she would have expected the medications ordered to be given in the form and dosages ordered. Based on 4 medication errors observed out of a possible 26 opportunities, the facility medication error rate was a calculated 15.83 percent. 28 Pa. Code 211.12(d)(1) Nursing services.